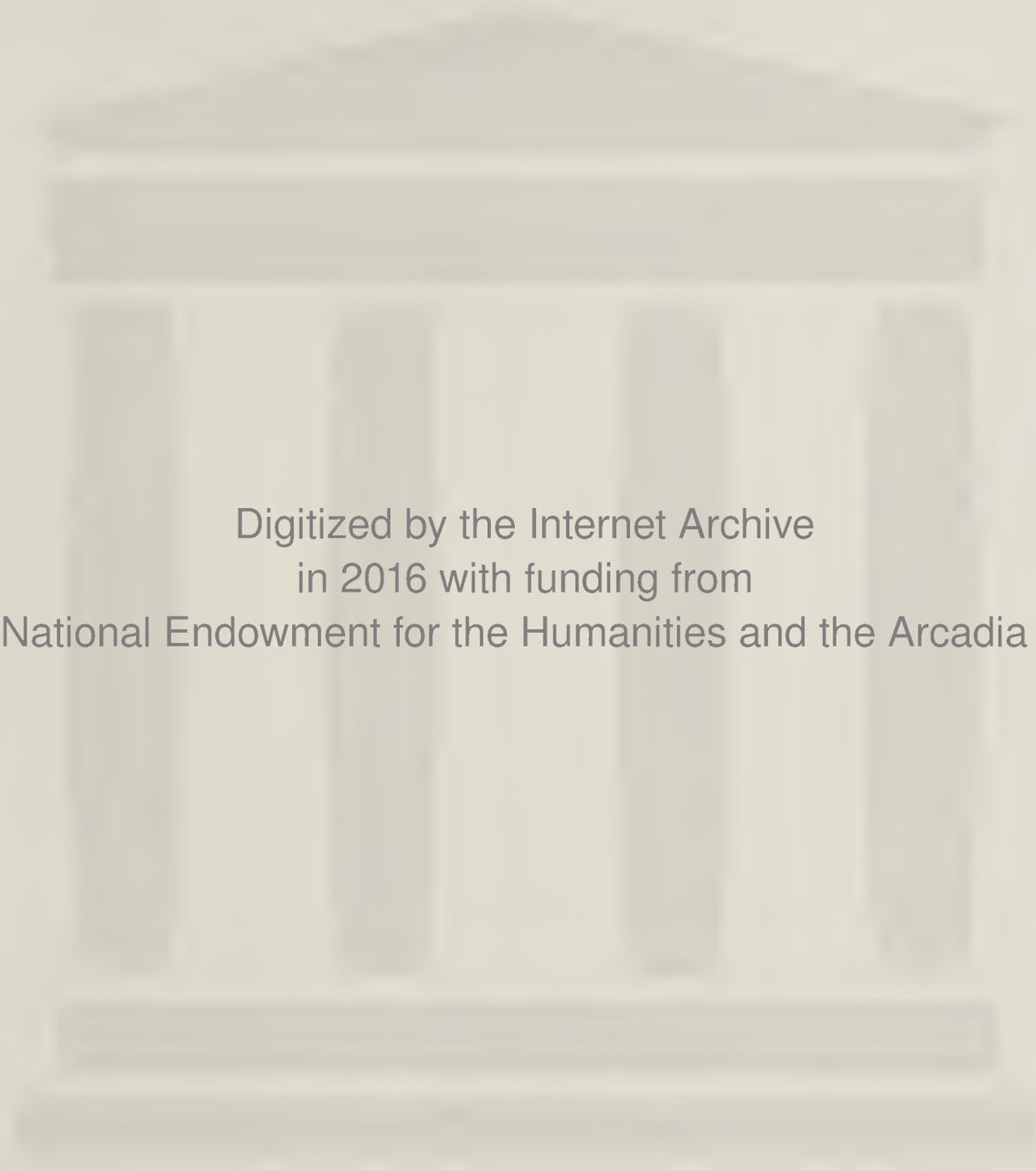
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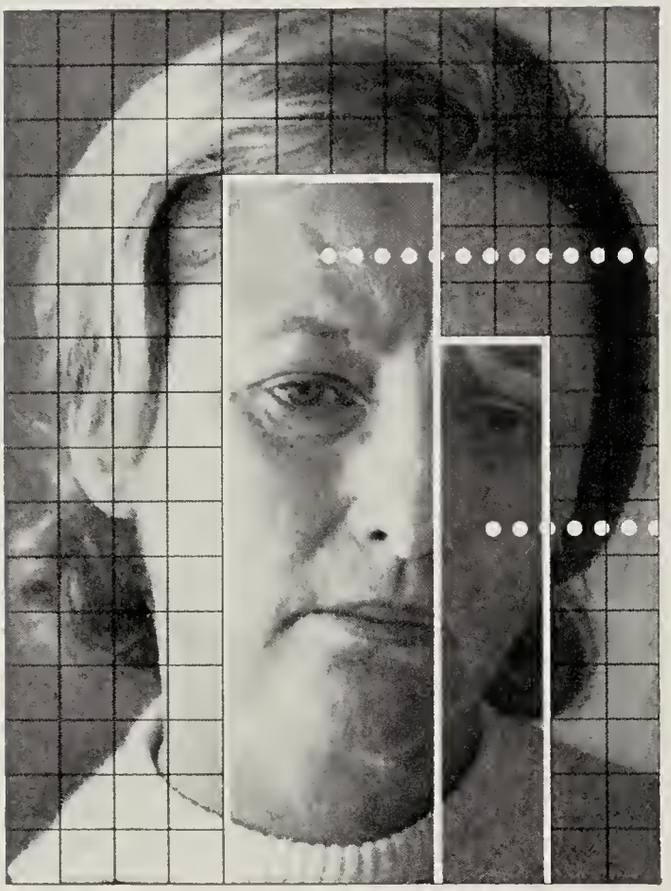
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This Month . . . Acute Renal Failure, Dr. Thomas Isom, Rose Bengal Liver Scanning

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
January 1975, Vol. XVI, No. 1

ORIGINAL PAPERS

Acute Renal Failure

ALVIN E. BRENT, M.D., and JOHN D. BOWER, M.D.
Jackson, Mississippi

THE DIAGNOSIS and management of acute renal failure was reviewed and published in this journal in 1967. Since then there have been changes in the etiology, diagnosis and treatment of this disorder. This article represents a current review of the subject.

Acute renal failure can be defined as the sudden cessation of renal excretory and homeostatic function. Acute renal failure is usually, but not always, associated with a diminished urine volume. Because of the loss of excretory function there is a build-up of the end products of metabolism which will eventually lead to the development of the uremic syndrome, acidosis and hyperkalemia. There are also disorders of water balance so that overhydration or underhydration frequently occur.

Acute renal failure may be classified into the following categories: (1) Pre-renal, (2) Parenchymal, (3) Post-renal. This classification is an oversimplification because there is actually a merging or gray zone between pre-renal and parenchymal renal failure.

In pre-renal azotemia there is oliguria and rising BUN and creatinine, but there is not yet anything wrong with the kidney. (See Table I) This may be brought about by anything which decreases renal blood flow such as shock or dehydration. It may also be seen in any condition associated with diminished renal blood flow such as heart failure and cirrhosis. In pre-renal azotemia, correction of the underlying cause frequently will reverse the oliguria and azotemia. Pre-renal azotemia may be worsened by drugs which interfere with protein metabolism, such as tetracyclines or steroids. Ammonium chloride can also cause an increase in blood urea nitrogen.

Acute renal failure is defined by the authors as the sudden cessation of renal excretory and homeostatic function. They classify it into three categories: pre-renal, parenchymal and post-renal, and give a current review of the etiology, diagnosis and treatment of acute renal failure. Four case reports conclude the article.

Post-renal failure is caused by urinary tract obstruction. Obstruction should always be considered in acute renal failure and should be the first condition to be ruled out. In early obstruction an infusion pyelogram may allow visualization of the kidney and upper collection system. A bladder catheter can be used to rule out a lower urinary tract obstruction. A plain film of the abdomen may lead to the diagnosis of ureteral stones. Any patient who is acutely azotemic and has only one kidney should be considered a prime candidate for urinary tract obstruction. In the presence of total anuria, obstruction should always be strongly considered since other causes of acute renal failure usually do not produce anuria. In patients with a history of analgesic abuse, diabetes mellitus or pyelonephritis, obstructon should

From the Departments of Medicine, St. Dominic and University Hospitals, Jackson, Miss.
Presented before the Medical Staff, Hinds General Hospital, Jackson, Miss., June 25, 1974.

also strongly be considered. In these instances the obstruction may be due to papillary necrosis and sloughed papillae. A history of abdominal or pelvic malignancy should alert one to the possibility of obstruction.

There are numerous causes of parenchymal renal disease associated with acute renal failure. (See Table II) Primary glomerular disease such as acute post streptococcal glomerulonephritis and collagen diseases such as lupus erythematosis will not be discussed here. These disorders can usually be diagnosed on basis of history, physical examination and lab findings including urinary sediment. Primary vascular problems such as renal arterial stenosis or venous thrombosis will not be discussed here. If suspicion of a vascular problem exists, then arteriography or venography will be required.

TABLE I

PRE-RENAL
1. Shock, dehydration, diminished effective volume
POST-RENAL
1. Obstruction

Other causes of acute renal failure due to renal parenchymal disease could be listed as follows:

(1) Conditions listed under pre-renal azotemia, i.e. shock or dehydration, if untreated, will progress to acute tubular necrosis.
(2) Nephrotoxic drugs and chemical compounds
   a. Antibiotics—Gentamicin, Kanamycin, Colimycin, Streptomycin, Amphotericin, Vancomycin, cephaloridine, methicillin, and mercurials.
   b. Industrial compounds—carbon tetrachloride, ethyleneglycol, and methanol.
   c. Lead, arsenic, mercury.
   d. Anti-neoplastic agents and resultant hyperuricemia.
(3) Hypercalcemia, hypokalemia and hyperuricemia.
(4) Myoglobin or hemoglobin precipitation may occur in renal tubules. Myoglobinuria may occur after crush injuries or prolonged seizures. Hemoglobinuria occurs after transfusion reactions or hemolysis of any cause.

In the usual clinical situation there are multiple etiological factors present. An example is a patient who has had extensive trauma, multiple surgical

TABLE II

PARENCHYMAL
1. Nephritis-post strep, collagen diseases
2. Vascular-arterial, venous, malignant hypertension
3. ATN—a pre-renal b-drug
4. Chemicals
5. Mb, Hb
6. Ca, K, uric acid
7. Cortical necrosis

procedures, mis-matched transfusions, repeated GI bleeding episodes and has received nephrotoxic drugs including several of the nephrotoxic antibiotics. In this situation, numerous factors are present which may be playing a part in the renal failure. Myoglobinuria from the crush injuries, hemoglobinuria from transfusion reactions, hypotension from blood loss and inadequate fluid and blood replacement may all play a mediating role. It is frequently difficult to determine the exact state of the patient's hydration. Intravascular volume depletion may or may not be present. In acute tubular necrosis and intravascular volume depletion oliguria is almost always present. Oliguria is defined as a urine volume of less than 20 cc per hour. It is important to recognize pre-renal azotemia early because with early treatment progression into acute tubular necrosis may be arrested.

MANAGEMENT

In the situation described above or in any similar patient we would recommend the management of such a patient as follows. The first step would be to obtain baseline blood and urine specimens and determine the state of hydration. Next begin to correct any underlying fluid deficits or excesses which may be present which could vary from requiring whole blood replacement, colloid, or electrolyte solutions to zero fluid intake. Gastric losses can generally be measured; fluid loss from diarrhea and sweating can be estimated. It should also be remembered that third space loss may occur such as into the abdominal cavity or into an extremity following a burn or injury. Clinically, as mentioned above, the state of hydration may be difficult to determine. An accurate weight at the time of admission combined with daily weights is helpful. The presence or absence of neck vein distention may be a good sign. A postural fall in blood pressure may indicate inadequate circulatory volume. Skin turgor, moisture of mucous membranes and ocular tension may be of some value.

If the patient's hydration appears adequate or the underlying deficits have been corrected, then the following steps are recommended. Prior to correcting hydration or ruling out obstruction, a random urinary specimen for urea, creatinine and sodium is obtained. (See Table III) If the urinary sodium is low, that is below 10 mEq per liter, then it is likely that pre-renal azotemia is the problem. Also a high urine osmolarity and a urine urea to plasma urea ratio of greater than 10/1 may also indicate a contracted intra-arterial volume. The most valuable of these tests is the urinary sodium. The urinary sodium is of most value when it is low and generally it does indicate volume depletion.

TREATMENT

After the urine specimen for sodium has been obtained it has been our practice to give 80 to 200 mgm of furosemide IV. If the patient is not already hyperosmolar, 12 to 25 gm of Mannitol also may be given IV. This is usually followed by the infusion of 500 to 1000 cc of normal saline over the next two hours if the patient is not overhydrated clinically. This procedure can be done more safely if the central venous pressure is being monitored. It is postulated that these procedures will reverse some parenchymal renal failure by eliminating casts and cellular debris from the renal tubules as well as be of diagnostic vaue. It is felt that Mannitol may actually in some cases reverse the process of acute renal failure if given early. Furosemide by promoting diuresis may also help reserve this problem In addition to clearing tubules of cellular debris and casts these agents also, by increasing urine volume, will reduce the concentration of any nephrotoxic drugs or agents which may be present in the renal tubules. If the urine output increases substantially following the above procedures, that is 60 to 100 cc per hour, then it is felt safe to continue to administer fluids usually in the form of ½ normal saline replacing the previous hour urinary output. Generally, after some 24 to 36 hours, the problem is corrected and acute renal failure is no longer a threat. If the urine output falls to as low as 30 cc per hour then a repeat injection of Lasix can be given at this time. Continued infusion of Mannitol without an adequate volume response may actually worsen the situation and cause the patient to develop acute pulmonary edema. If the urine volume increases, but not to the amount mentioned above, then a repeat of the above procedures is indicated unless the patient appears to be overhydrated or develops an elevation in central venous pressure. If by following the above proccdures no increase in urine output occurs, then acute tubular necrosis apparently is well established and treatment from this point on generally is fluid restriction.

TABLE III

ATN vs PRE-RENAL
1. Urine Na
2. Urine urea, cr to plasma ratio
3. Furosemide response
4. Mannitol

ACUTE TUBULAR NECROSIS

The three phases of acute tubular necrosis are: (1) Oliguria, (2) Diuretic, (3) Convalescence.

The oliguric phase of acute renal failure generally takes 7-11 days, but complete recovery after as long as two months has been reported. (See Table IV) Fluid therapy during the oliguric phase is carried out as follows: in an adult, about 400 cc of fluid per day, which is an estimate of insensible fluid loss from lungs and skin, plus any measured output is replaced. Fluid orders might be calculated as follows: 400 cc daily plus the prior day's output, plus any other measured fluid loss such as from the G.I. tract. Insensible loss would need to be increased in the presence of sweating, high fever, and hyperventilation. Daily measurement of electrolytes and creatinine are made during the oliguric phase. Electrolytes are replaced according to their measured losses and plasma values. The losses may actually be measured in body fluids or they may be estimated.

TABLE IV

ATN—MANAGEMENT
1. Correct deficits
2. ATN vs pre-renal
3. Fluids
4. K
5. Acidosis
6. Nutrition

Best measure as to the adequacy of fluid replacement is the daily body weight. Ideally, an average of about 0.5 kg of body weight loss per day should occur. A weight gain or no loss indicates that excessive fluid is being administered. In addition to fluid replacement, adequate carbohydrate intake is necessary. A minimum of 100 grams of carbohydrates per day should be given. This amount of

carbohydrate has been shown to aid in preventing the breakdown of body protein. This carbohydrate can be given as IV glucose or preferably, if possible, should be given by the oral route. A mixture of half Karo and half ginger ale provides 0.5 grams or 2 calories of carbohydrates per cc while containing no protein and virtually no electrolytes. Additional carbohydrates can also be provided in the form of hard candies.

Hyperkalemia may also be a problem during the oliguria phase. This is particularly true if the patient is very catabolic or has been given potassium prior to the onset of acute renal failure. Life-threatening hyperkalemia can develop very rapidly if the patient becomes acidotic. An ion exchange resin such as Kayexalate which can be given orally or by enema usually will control the hyperkalemia. Kayexalate removes potassium by exchanging sodium for potassium in the G.I. tract. One mEq of sodium is added for each mEq of potassium which is removed. Emergency management of hyperkalemia consists of an IV administration of calcium, $NaHCO_3$, or insulin and glucose. Attempts should be made to keep the CO_2 combining power above 15 mEq per liter. This can be done by the administration of sodium bicarbonate or Shohl's Solution. Shohl's Solution contains sodium citrate which is converted to bicarbonate in the body. Average intake required of HCO_3 to do this is about 45 mEq per day. One gram of sodium bicarbonate contains 12 mEq of bicarbonate. Shohl's Solution contains 1 mEq of bicarbonate per cc.

DIALYSIS

Dialysis may be required during the oliguric phase. The following are generally considered to be indications for dialysis: (1) Uremic symptoms, (2) BUN over 125 mg per cent, (3) Creatinine over 8 mg per cent, (4) Fluid overload, (5) Unconnectable electrolyte abnormalities, particularly hyperkalemic and severe acidosis, (6) Presence of dialyzable nephrotoxic drugs.

The central nervous system symptoms of uremia that indicate a need for dialysis are increasing lethargy, coma, convulsions and mental confusion. Symptoms referable to the G.I. tract such as loss of appetite, nausea, and vomiting may indicate a need for dialysis. Bleeding tendencies, pericarditis and uremic pneumonitis may also prompt dialytic intervention. These signs and symptoms do not usually occur until after the creatinine has reached at least 8 mg per cent. Earlier dialysis may be required for iatrogenic fluid overload, hyperkalemia or severe acidosis. If a toxic dialyzable compound is present such as methanol, ethyleneglycol, carbon tetrachloride or a nephrotoxic antibiotic, then this may also be an indication for earlier dialysis.

Dialysis may be either peritoneal or hemodialysis with the artificial kidney. Peritoneal dialysis is contraindicated in the presence of recent abdominal surgery, extensive abdominal adhesions, ascites, peritonitis, and presence of a colostomy. Peritoneal dialysis is a much simpler method of dialysis in that it does not require a large equipment investment. Usually 30-40 two liter exchanges are performed. Following this the peritoneal catheter is removed and reinserted as needed if further dialysis is required. Complications specific to peritoneal dialysis are visceral perforation at the time of catheter insertion and peritonitis due to fluid contamination. Hemodialysis is a much faster procedure. Dialysis is generally four times faster with the artificial kidney. The major disadvantages of hemodialysis are the cost and staff requirements of highly trained personnel. It also requires some form of artery and vein cannulation. Hemodialysis is specifically indicated if the patient is severely catabolic and more rapid dialysis is felt to be needed. Inaccessibility of the peritoneal cavity and an extremely catabolic patient usually necessitate hemodialysis.

The diuretic phase generally occurs after some 10 to 14 days. Urine volumes may reach 6 to 10 liters per day, particularly if the patient was overhydrated in the oliguric phase. This fluid must be optimally replaced since dehydration may be encountered during this salt losing phase. Occasionally one may see a situation of continued polyuria which is being perpetuated by continued aggressive fluid replacement. In this situation, fluid can be withheld for several hours and the output observed. Initially in the diuretic phase the BUN may rise and hyperkalemia may actually worsen.

CASE REPORTS

Case No. 1: H. B. #314274, a 56-year-old white male, was referred with the impression of chronic end stage renal disease. The patient gave a history suggestive of lower urinary tract obstruction for years. He had noted nocturia 8-9 times per night, hesitance, dribbling, and straining with urination. For 1-2 weeks prior to admission, he had developed symptoms of malaise, anorexia, and nausea. He also

recently developed bilateral flank pain. He became acutely anuric and required foley catheter insertion 1 week prior to admission to UMC. BUN was reported as 180 mg per cent and creatinine 11 mgm per cent. There was no history of renal lithiasis. He had been treated on several occasions for urinary infections during the past year. The other pertinent point was a history of mild hypertension. Physical findings showed the following: BP 130/70, PR 80, RR 18, wt. 185. He was not in acute distress. Eye grounds showed only minimal arterial narrowing. Lungs were clear. No clinical cardiomegaly was present. A normal rhythm and no murmur or gallop were found. Examination of the abdomen showed no organomegaly. A trace of peripheral edema was present. Prostate was described as 3+ enlarged without nodularity. A foley catheter was in place. Initial lab data showed a BUN of 175 mgm per cent and creatinine 7.2 mgm per cent, Hb 13.5, Hct 39.7 per cent, WBC's 21,800. Urinalysis showed 25-30 WBC's per high power field. With catheter drainage, he underwent a post obstructive diuresis with urine volumes as high as 7 liters per 24 hours. Serum creatinine had fallen to 2.9 mgm per cent after 2 weeks of catheter drainage at which time he had a retro pubic prostatectomy. His postoperative course was uncomplicated other than transient temperature elevation after foley catheter removal. Creatinine at time of discharge was 2 mgm per cent and BUN 26 mgm per cent. This case was felt to illustrate well the reversibility of uremia secondary to urinary tract obstruction.

Case No. 2: L. B. #311629, a 53-year-old negro female, had a cholecystectomy 3½ weeks prior to University Hospital admission. An admission BUN of 31 and creatinine of 2.2 mgm per cent were reported. She received Kanamycin 0.5 gm b.i.d. for 16 days. One week after her cholecystectomy, she required a common duct exploration. She was readmitted to her local hospital 5 days before admission to UMC with symptoms of disorientation, confusion, nausea and vomiting. At that time she was found to be oliguric and BUN was reported as 180 mgm per cent with creatinine 35.5 mgm per cent. Pertinent previous history included hypertension for which she had taken intermittent therapy and diabetes mellitus treated with oral agents. Physical findings showed a BP of 150/91, P 100, wt. 108.5 kg. She was found to have a marked nerve deafness. Lung fields were clear. Examination of her heart showed a normal rhythm with a grade II/VI systolic murmur. No organomegaly was found. Two plus peripheral edema was present. Initial findings were BUN 240 mgm per cent and creatinine 20.1 mgm per cent, Co_2 C.P. 5, K 6.3, Na 142, Cl 105. Hemodialysis was begun on the day following admission. She required hemodialysis on 6 occasions. She was oliguric initially and never had a marked diuresis. Creatinine was 2.7 mgm per cent and BUN 12 mgm per cent at the time of discharge with a creatinine clearance of 25 ml/min. She remained almost totally deaf. This case was felt to represent a patient with relatively mild azotemia probably due to diabetes mellitus and nephrosclerosis with an acute exacerbation secondary to Kanamycin toxicity.

Case No. 3: P. T. #201562, a 23-year-old male, had a stab wound to the abdomen 2 days prior to admission. He became hypotensive on the day following his injury and was transferred to St. Dominic Hospital. There was no prior history of renal disease, hypertension or heart disease. On arrival he was in shock and an emergency abdominal exploration was performed after treatment with fluids and whole blood. He was oliguric after surgery with urine output of 5-10 cc per hour. Physical findings revealed prominent neck veins, moist mucous membranes and good skin turgo. His lungs were clear and he was found to have BP 130/90, P 84. He was given 80 mgm Lasix IV and 12.5 gm Mannitol IV. Following these he showed no change in his urine output. A urine Na was 30 mEq per liter. He remained oliguric with BUN reaching 196 mgm per cent and creatinine 10.2 mgm per cent. Peritoneal dialysis was initially begun but due to development of peritonitis he was later treated with hemodialysis. He had a prolonged hospital course with later development of pneumonia, but he eventually recovered and was discharged. This case was felt to represent the findings seen in acute tubular necrosis.

Case No. 4: An 89-year-old white male was admitted to his local hospital with an acute flare-up of chronic obstructive lung disease. He was treated with IPPB, expectorants and antibiotics (ANCEF cephalosporin antibiotic, and a tetracycline antibiotic). He previously had been in good health except for a mild chronic brain syndrome believed due to arteriosclerosis. While in the hospital he developed pain and discoloration of the left lower extremity. Following this he became hypotensive. He was found to have absence of pulses in the left lower extremity and was transferred for further care. He was hypotensive for a period of 2 hours. On arrival to the emergency room his BP was 100/70, P 100. He

had wheezes over both lung bases. Absence of pulses in the left lower extremity was confirmed. Embolization was suspected and he was immediately taken to surgery. An embolectomy with a fogarty catheter was performed. Following this procedure he had a return of pulses and good coloration. He was oliguric postoperatively. He initially was given 2 units of whole blood but remained oliguric. He was given small injections of Lasix 20 and 40 mgm but did not show a change in his urinary output. Consultation with the renal service was obtained the following day. At this time his urine output was 5-10 cc per hour. A urine Na was 18 mEq/liter. He was given 80 mgm Lasix and 12½ gm Mannitol IV. The urine output increased to 100-150 cc per hour. He was given 50 cc ½ NS with 5 per cent glucose plus his prior hour's output. He continued an uneventful recovery. This patient was felt to illustrate the findings in pre-renal azotemia.

CONCLUSION

Acute tubular necrosis is not an uncommon condition. It has been reported to have occurred in some degree in 20-30 per cent of patients who receive extracorporeal bypass. Approximately 5 per cent of patients receiving extracorporeal bypass have kidney failure severe enough to require dialysis. It may also occur after major trauma or after shock of any cause. Today, probably the most common contributing factor is the injudicious administration of drugs especially the nephrotoxic antibiotics. Sepsis and shock are probably the second most common cause of acute tubular necrosis. Frequently, as mentioned earlier, there are multiple etiologic factors present.

In the second World War and the early Korean War the mortality in acute renal failure was approximately 90 per cent. With the advent of dialysis this figure has been reduced to less than 50 per cent. The overall mortality, however, has remained unchanged for the past 15 years. Recently an advance in survival rate was reported in the *New England Journal of Medicine*. A significant reduction in mortality was obtained by IV feedings of essential amino acids and glucose. This is also described as parenteral hyperalimentation. The most common cause of death remains sepsis. Frequent pulmonary complications are pneumonia and shock lung. Pulmonary congestion is also frequently seen due to overhydration in an attempt to force a diuresis. This cannot be done in acute tubular necrosis. Patients also may die of their underlying disease which leads to the development of acute renal failure to start with. Hyperkalemia, although the major cause of death in the past, is now a less frequent cause. No patient should die of acute uremia since dialysis facilities are available to all patients. There are no criteria for patient selection in the area of acute renal failure except potential reversibility at the renal level. Emphasis should be placed on early recognition, treatment, and possible prevention. Caution in the use of nephrotoxic drugs will also prevent much of the acute tubular necrosis that is being seen. ★★★

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This announcement appeared in the Church Bulletin: "Next Sunday there will be services at the north and south wings of the church. Children will be baptized at both ends."

Dr. Thomas Dudley Isom: Member First Mississippi State Board of Health

BEULAH M. D'OLIVE PRICE
Corinth, Mississippi

THIS IS THE fourth in a series of biographical sketches of members of the first Mississippi State Board of Health which was established in 1877.

Dr. Thomas Dudley Isom was born in Maury County, Tennessee, Sept. 5, 1816. His parents, James and Mary (Gale) Isom were natives of Virginia and pioneers in middle Tennessee. Dr. Isom's early education was obtained at Pebble Hill Academy in Rutherford County, Tennessee.[1]

In 1835, before the removal of the Chickasaws, Dr. Isom came to Tullahoma, Mississippi. From there he was sent by a company with a stock of goods to trade with the Indians. Dr. Isom established his store on the present site of Oxford. He is said to have been the first white settler and merchant in that place where he remained until the Indian removal.[2]

Returning to Tennessee Dr. Isom studied medicine for a year under Dr. John S. Spindle. In 1837-38 he took a course of lectures at Transylvania University. He then studied at Jefferson Medical College in Philadelphia where he was graduated in 1839.[3]

After completing his medical training Dr. Isom returned to Oxford to begin his practice and lived there for the remainder of his life except for periods during the Civil War.[4]

In 1861 Dr. Isom entered the Southern army as a surgeon in the 14th Mississippi Volunteer Infantry and that same year opened a hospital at Warrenton, Virginia. In the spring of 1862 he returned to Oxford and opened a hospital there in the university buildings where 1500 of the sick and wounded from the battle of Shiloh were treated. In the fall and winter of 1862 Dr. Isom was post surgeon at Jackson and Columbus. In 1863 he was appointed to the Army Medical Board and continued in this capacity until the end of the war.[5]

Dr. Isom then returned to private practice in Oxford and by 1890 he "enjoyed the distinction of being the oldest and most extensive practitioner in Northern Mississippi in all branches of his profession."[6] He was credited with being the first to demonstrate "in this locality the possibility of treating febrile diseases of malarious and malignant type with large doses of quinine."[7]

Dr. Isom's success as a surgeon was attested by such cases as the extirpation in 1856 of the superior maxillary bone, patient still living (1890); many successful operations in all hernias; extensive operations in extirpating tumors and he was "first in the area to apply Sayre's plaster jacket in Pott's disease."[8]

Dr. Isom was a member of the Secession Convention in 1860 and of the Constitutional Convention in 1890.[9]

Nine children were born to Dr. Isom and his wife Sarah R. (McGehee) Isom of Abbeville District, South Carolina. Four of the nine were still living in 1890. These were Mary F. Petrie, Emma G. Branhaw, Sarah McGehee Isom and Thomas Dudley Isom, Jr., M.D.[10]

Dr. Isom served as a delegate to the American Medical Association in 1872. In 1878 he was elected vice-president of the Mississippi State Medical Association.[11]

The grave of Dr. Isom is in St. Peter's Cemetery in Oxford. (He died in 1902.) His antebellum home is on Jefferson Street.[12] It is said that Dr. Isom's slaves dug the deep railroad cut known as Hilgard's

Cut which is bridged on University Avenue.[13]

It is interesting to note that Dr. Isom's daughter, Miss Sarah MeGehee Isom, became, in 1885, the first woman on the faculty of the University of Mississippi.[14]

★★★

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14. Allen Cabiness: The University of Mississippi: Its First Hundred Years. University and College Press, 2nd edition. p. 9, 1971.

TO CONFIRM A DIAGNOSIS OF INFLUENZA

1. *Serological:*
   (A) Obtain a 5-10 cc whole blood from patient during the acute phase of the illness.
   (B) Repeat in 2-4 weeks to obtain convalescent blood specimen.

   (Send both specimens to State Laboratory immediately, properly identified.)
2. *Virus isolation:*
   Swab from the posterior pharynx within 48-72 hours after onset. Place in broth of tryptose-phosphate-gelatine buffered, if available, or use swabs dipped in N/saline. Send specimen to State Laboratory on dry ice, or deliver to Laboratory fresh within three hours.

Bureau of Disease Control
State Board of Health

Radiologic Seminar CXXXXVII: Rose Bengal Liver Scanning

JANE A. SANDERS, M.D., and W. M. FLOWERS, JR., M.D.
Jackson, Mississippi

RADIOIODINATED Rose Bengal liver scanning is useful whenever the clinical problem involves differentiating jaundice resulting from intrahepatic obstruction from that caused by extrahepatic obstruction. The test is particularly accurate in the evaluation of biliary tract patency; when prompt intestinal activity is seen, the possibility of extrahepatic obstructions is remote.

Rose Bengal dye (tetraiodo-tetrachlorfluoroscein), tagged with 131-I, is cleared quantitatively from the blood by the polygonal cells of the liver in a manner similar to bromsulfalein and excreted via the biliary system into the duodenum and is eliminated in the feces.

It is excreted almost entirely into the intestinal tract with less than 5 per cent being recovered in the urine. However, in intrahepatic or extrahepatic obstruction the amount of radioactivity recovered from the urine may be as great as 35-40 per cent and the kidneys can be visualized.

The rate at which 131-I Rose Bengal is removed from the blood is determined by the functioning capacity of the polygonal cells, liver blood flow, and biliary tract patency. Impairment of any of these will produce a discernible change in the hepatic uptake and excretion of the dye.

A dose of 150 μCi is given intravenously. The maximum hepatic uptake occurs between 30 and 40 minutes and the dye first appears in the gallbladder and/or small bowel between 15 and 20 minutes. The usual scan procedures are begun at 15 minutes after injection and followed with repeat studies at 2 hours and 12 or 24 hour intervals; but in cases of obstruction the study may be continued at intervals up to 4 days.

In primary liver disease rates of blood disappearance and liver accumulation and excretion are slowed according to the degree of the disease. In biliary obstruction the dye continues to accumulate in the liver but is not seen to enter the bowel.

Intrahepatic cholestasis associated with some forms of hepatitis may be severe enough to impede the flow of dye. Therefore it is important to get delayed studies to at least 24 hours before suggesting a diagnosis of biliary tract obstruction.

CASE REPORTS

Case No. 1: A 48-year-old white female was admitted with complaints of malaise, anorexia, nausea, vomiting and generalized right upper quadrant pain. Four months prior she had been tranfused with one



Figure 1. Forty-five minutes after injection there is normal liver activity. The area of increased activity at the inferior liver edge is concentration in the gallbladder.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi Medical Center, Jackson, Miss.



Figure 2. Two and one half hours after injection there is decreased liver activity and diffuse activity in the bowel, indicating biliary patency.



Figure 3. Forty-five minutes after injection there is normal liver activity but no evidence of activity in the gallbladder or small bowel. A repeat scan at 4 hours showed no change.

unit of whole blood following a bilateral simple mastectomy for cystic breast disease. The patient was slightly jaundiced and had a bilirubin level of 4.8 mg per cent with 3.3 mg per cent direct. Alkaline phosphatase was 185. An 131-I Rose Bengal liver scan showed normal activity at 45 minutes after injection and visualization of activity within the gallbladder (see Figure 1). At 2.5 hours after injection there was decreased liver activity and diffuse activity was seen in the bowel confirming biliary patency (see Figure 2).

The patient was felt to have serum hepatitis and gradually responded to medical treatment.

Case No. 2: A 53-year-old white female was admitted with a 6 to 8 week history of right upper quadrant and epigastric pain radiating to the right scapula. She also had increasing jaundice, light stools, dark urine and a 15 lb. weight loss over the past 6 months.

The patient was noticeably jaundiced with a bilirubin level of 8.4 mg per cent with 5.8 mg per cent direct. Alkaline phosphatase was 300.

An 131-I Rose Bengal liver scan showed normal liver activity 45 min. after injection but no activity in the gallbladder or small bowel (see Figure 3). A repeat study at 4 hours showed essentially the same appearance. A delayed scan at 24 hours failed to reveal any activity in the small bowel (see Figure 4): thus strongly suggesting extrahepatic obstruction.

At surgery the patient was found to have a large undifferentiated adenocarcinoma invading both the



Figure 4. At 24 hours there is still activity in the liver with no evidence of gallbladder or small bowel activity, indicating extrahepatic obstruction.

gallbladder and the liver and completely obstructing the common bile duct.

SUMMARY

Because of the characteristics of 131-I Rose Bengal, it has become a useful test for the differential diagnosis of jaundice, making it possible for the physician to separate the difficult problems of hepatitis or cholestasis from that of obstructive jaundice.

★★★

2500 North State Street (39216)

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1. Dynamic Clinical Studies With Radioisotopes and the Scintillation Camera. II. Rose Bengal ^{131}I Liver Function Studies. JAMA 198:140-150, Nov. 7, 1966.
2. The Use of 131-I Rose Bengal Scans in the Diagnosis of Biliary Obstruction. American Surgeon 38:328-332, June, 1972.
3. Metabolic and Physiologic Aspects of 131-I Rose Bengal in Studying Liver Function. Seminars in Nuclear Medicine. 2:157-67, April, 1972.
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5. Blahd: *Nuclear Medicine*. New York, McGraw-Hill, Inc., pp. 363-374.

	Dosage	*Physical Half-life*	*Liver Half-time*	*Liver Dose (Rads)*	*Whole Body Dose (Rads)*
131-I Rose Bengal	150 μCi	8.1 days	2 hours*	.25-.50	.05-.15

* The half-time in the liver will be prolonged and the radiation dose will be increased if there is biliary obstruction.

TEARING DOWN

I stood on a corner in a busy town
watching men tear a building down

with a yo heave ho and a lusty yell
they swung a boom and a side wing fell.

I asked the foreman of this mighty crew
"are these men skilled as those who build anew?"

"oh no," said he, "oh no, indeed!
common labor is all I need

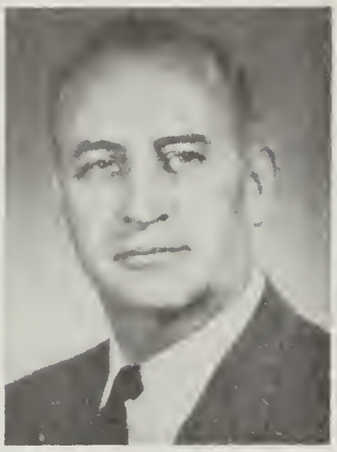
why, I can tear down as much in a day or two
as it takes skilled men a year to do."

and I thought to myself as I walked away
"just which of these roles am I trying to play?

"do I walk life's busy way with care
measuring each deed with rule and square?

"or am I just one who goes around
content with this business of tearing down?"

Author Unknown



The President Speaking

We Need You!

J. T. DAVIS, M.D.
Corinth, Mississippi

THE YEAR 1975 promises to be an important and eventful one for our profession. National health insurance and other medical issues will be prime topics before the 94th Congress. The Mississippi Professional Standards Review Organization Program will begin implementation in February. The 1975 Mississippi Legislature will convene this month and Mississippi executive and legislative office holders will stand for election later this year.

Our profession will be called on to demonstrate its concern and interest in these activities. Are we ready? The organizational structures are in place in the form of our national, state, and county medical societies, the Mississippi Foundation for Medical Care, and the Mississippi Medical Political Action Committee. Are you participating in the activities of these organizations? They can only be successful and represent our profession to the extent that we as individuals participate in their activities.

Will you attend the association's 107th Annual Session May 5-8, 1975, and regularly attend your county medical society's meetings this year? Have you volunteered to serve as "Doctor of the Day" in the association's Emergency Care Unit at the Capitol? Have you read the brochure that was recently mailed to you concerning PSRO implementation plans? Are you familiar with your legislators' health voting index? Now is the time to make plans to accomplish these and other individual professional obligations. Let no one doubt our concern and interest in the many important and eventful activities that will affect our profession in 1975. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVI, NUMBER 1
JANUARY 1975

EDITORIALS

A New Health Package—For Better or for Worse

With the expiration of authorizations for Comprehensive Health Planning, facility construction (Hill-Burton), regional medical programs, several manpower training programs, several direct health service programs (migrant health, neighborhood health centers, mental retardation and mental health) and others—all extended for one year in June 1973—Congress has written another bill, one designed to "free from politics" these health services.

It would in part create HSA's (Health System Agencies), comparable to the CHP b agencies. The Secretary of HEW, in consultation with the governor of the state involved, would select or designate these private corporations. These HSA's would be responsible for long and short term planning, development of services, for approval or disapproval of virtually all federal funds used through grants and contracts for support of health services, manpower and facilities, for certificate of need determination, and for review of existing health care services rendered by facilities to make a determination as to whether they should continue or not.

HSA's would have considerably more power than current CHP b agencies, better funding, and less responsibility to the state.

The principal objection to this proposed bill, HR 16204, seems to be to the combining of design, implementation, and regulatory powers in one board that may be self-perpetuating and have virtually no accountability to the public except indirectly through the Secretary of HEW.

It will be interesting to see what the final bill will be; certainly it will be of concern to providers and consumers alike.

W. Moncure Dabney, M.D.
Editor
Crystal Springs, Miss.

HEW Creates Nursing Home Mess

A senate subcommittee has accused HEW of repeated and costly failure to develop any kind of coherent public policy to protect the elderly from abuses in nursing homes or to offer alternative care.

Sen. Frank E. Moss (D-Utah), chairman of the subcommittee on long-term care of the special committee on aging, said HEW has been guilty of "neglect, indifference, and ineptitude" in providing safeguards. The subcommittee issued its findings in a 161-page volume released in November. It was the first in a 12-volume series on nursing home problems to be issued by the subcommittee at the rate of one a month for the next nine months. The 11th volume will comprise responses from the nursing home industry and other interested parties.

Moss said the purpose of the report "above anything else is to spur consideration of expanded nursing home coverage within the context of national health insurance." Expressing concern over possibly doing good nursing homes an injustice through this report, Moss said the sixth volume will deal with "innovative practices at good homes," which "unfortunately are in the minority."

The report, citing abuses of patients, unsanitary conditions, misuse of drugs, and fire hazards, says that more than half of the nation's 23,000 homes fail to meet federal standards. Moreover, large numbers of the elderly in nursing homes are not eligible for Medicare or Medicaid assistance to help pay for their care. And about 600,000 other elderly go without care, the report says, because they cannot afford the average $600 a month that institutionalization costs.

Medicaid now accounts for about 60 per cent of the nation's more than $3.7 billion nursing home

bill. Despite the sizeable commitment in federal funds, HEW has been reluctant to issue forthright standards to provide patients with minimum protection, the report says, and HEW even "watered down" prior standards after Congress in 1972 mandated the merger of Medicare and Medicaid standards (PL 92-503) and ordered retention of the higher standards in every case.

Although the Social Security Amendments of 1972 were passed nearly three years ago, HEW has not clarified the definition of "skilled care" or even written regulations for many of the amendments. The result has been widespread confusion in the states and in some cases states have applied the more rigid Medicare standards to their Medicaid programs.

The report devotes a chapter to "the need for alternatives to institutionalization," with concentration on home health care. Home health care has been found to be emotionally beneficial to the patient, less costly, as well as shortening the number of days of inhospital care. Although home health care is covered under Medicare, HEW has again cut back benefits through restrictive rulings—also rectroactively—and in fiscal 1973, paid out $75 million in home health benefits, down from $115 million in fiscal 1970.

Charles L. Mathews
Executive Secretary

Smoking Mothers and Infant Health

Cigarette smoking in pregnant women cannot be considered merely self-damaging. Several studies have demonstrated strong statistical associations between smoking by pregnant women and low birthweight infants, with definite increases in perinatal deaths.

More recently Harlap and Davies[2] have shown that maternal cigarette smoking is associated with statistically significant increases in hospital admissions for pneumonia and bronchitis for infants during the first year of life. This admission rate was positively related to the mothers' cigarette consumption.

Numerous investigations have shown that noxious agents in cigarette smoke often reach levels which substantially exceed national occupation air-quality safety limits in commonly used, confined, and poorly ventilated spaces (autos, trains, airplanes, etc.).

For most adult non-smokers cigarette smoke is at worst a source of annoyance and temporary irritation to eyes and respiratory passages. It is perhaps fortunate that cigarette smoke contains so many irritants—for they usually ensure that the non-smoker takes some protective action such as breath-holding, shallow breathing, opening a window, or leaving the room.

It is indeed a sad indictment that, apart from the unborn child, the one non-smoker who cannot protect himself is the infant left at the mercy of his mother's smoke.

Durward Blakey, M.D., Director
Bureau of Disease Control
State Board of Health

REFERENCES

1. Simpson, W. J.: Am. J. Obstet. Gynec. 73:807, 1957.
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Medico-Legal Briefs

HUSBAND MAY NOT PREVENT WIFE FROM HAVING ABORTION

A husband has no fundamental right to determine that his child should not be aborted, the highest court of Massachusetts ruled.

A husband who was estranged from his pregnant wife brought an action to prevent her from undergoing an abortion. At the time the wife became pregnant, both she and her husband wanted the child. However, a few months later they separated, the husband telling the wife he did not want to support the child and that he did not want his name on the birth certificate as the father.

The wife then said she wanted to terminate the pregnancy because she could not handle two children (she had a child by another man before she married). The husband objected to an abortion and declared that he was willing to assume custody and to support the child. He had considered arrangements for its care, including day care by his wife's sister.

The wife said she would never consent to giving custody of the child to her husband. The husband then sought to restrain the abortion.

A single justice of the highest court appointed a guardian for the unborn and granted a temporary restraining order to prevent the abortion. The full court then heard the case and vacated the restraining order.

The husband had no constitutional right to determine that his child not be aborted, the court said. Although the cases he relied on recognized a right of privacy against governmental action, the court said, they did not establish a basis to permit the state to interfere in a dispute with his wife.

No Massachusetts statute gave the husband any right to prevent an abortion, and many states made no mention of a husband's consent in their abortion laws. The U. S. Supreme Court decisions on abortion used language inconsistent with any such right of the husband, the court said. A decision for or against an abortion was solely that of the woman and her physician during the first trimester, the U. S. Supreme Court had said. Cases in other states had also denied similar claims by husbands.

Many delicate questions inherent in the marriage relationship are not resolved by law, the court concluded. Some things must be left to private agreement.

Two justices filed dissenting opinions. One felt that the rights of the father were dominant. The wife had a duty to refrain from intentional interference with the progress of her pregnancy in justice to her husband, he said. The other dissenter also felt that the balance of interests fell in favor of the potential father.—*Doe v. Doe,* 314 N.E.2d 128 (Mass.Sup. Jud.Ct., July 3, 1974)

PERSONALS

William M. Aden announces the opening of his office for the practice of ophthalmology at Suite 306, Medical Plaza Building, 1600 N. State Street, Jackson.

Jare Barkley of Gulfport announces the relocation of his surgical clinic to 611 Broad Avenue in Gulfport.

Thomas Barnes of Greenville, 1974-75 president of the American Cancer Society, Mississippi Division, presided over the recent annual meeting of the division.

Charles P. Bass has associated with The Family Clinic Professional Association in the practice of general medicine at 502 Broad Street in Columbia.

Jack Biggs of Southaven has been named as the newest member of the Coahoma National Bank's Advisory Board.

Edgar E. Bobo of Pearl is serving as chairman of the health committee of Rankin County Chamber of Commerce.

William G. Bradley has associated with R. M. Brown of Booneville at 109 Washington Street for the general practice of medicine.

John F. Eckford of Starkville has been named Grand Marshal of the 1974 Christmas parade by the Oktibbeha County Christmas Parade Council.

John Evans of Vicksburg is new president of West Mississippi Medical Society. Other officers are John Ederington, vice president; M. E. Hinman, secretary-treasurer; and Tom Mitchell, delegate.

Frank Gruich of Biloxi has been awarded the Sam Owen trophy for distinguished service to Mississippi Gulf Coast Junior College.

Marvin Harvey of McComb was named chief of staff at Southwest Mississippi Regional Medical Center in McComb, and Julian James was named chief of staff at City Hospital, McComb.

Karl W. Hatten of Vicksburg has been appointed to the board of Vicksburg Hospital, Inc. Dr. Hatten is also serving as president of the Vicksburg Chamber of Commerce.

Robert Douglas Holbert has joined the faculty of the University Medical Center as assistant professor of medicine. Dr. Holbert is a graduate of Tulane Medical School and was formerly an instructor at LSU Medical Center.

Steve Izard has set up practice in Fulton and will occupy the former office of A. P. Spraberry who has returned to the University Medical Center in Jackson for a pathology residency.

Yousef Kurdy has set up practice at Mize. He is a graduate of the Aleppo University School of Medicine in Syria and completed internship at St. Joseph Hospital in Memphis.

Myron W. Lockey and James Arens of Jackson and UMC presented a paper at the Southern Medical Association annual meeting in Atlanta.

R. J. Lorentz of Picayune announces the removal of his office to 323 Vaughn Street, Hwy. 11 North for the practice of ophthalmology.

William M. McKell of Jackson announces the relocation of his office to St. Dominic Medical Offices, Suite 405, 971 Lakeland Drive in Jackson for

practice limited to gastroenterology and internal medicine.

FRANCIS S. MORRISON and CRAWLEY STUBBLEFIELD of Jackson and UMC presented papers at the Southwest Sectional Meeting of the American Association for Cancer Research in New Orleans.

GARY A. NELSON announces the opening of his practice for general and family medicine at 418 Clinton Boulevard in Clinton.

DEXTER C. NETTLES, GUY D. CAMPBELL, WALLACE CONERLY, JOSEPH C. GABEL and G. BOYD SHAW of Jackson and JOHN R. WILLIAMS of Greenville were on the faculty for the blood gases techniques workshop held at the Miss. Education and Research Center and sponsored by the University Medical Center.

EDWARD NORTH of Jackson, Exchange Club District President for Mississippi, was guest speaker at the regular monthly meeting of the Cleveland Exchange Club.

WILLIAM OWEN, a native of Gulfport, has set up practice in Raleigh at No. 1 Park Place.

DEATHS

WHEATON, ROBERT E., Meridian. Born Hattiesburg, Miss., Dec. 4, 1925; M.D., Howard University College of Medicine, Washington, D. C., 1957; interned McKeesport Hospital, McKeesport, Pa., one year; died Sept. 21, 1974, age 48.

NEW MEMBERS

WESSON, THOMAS W., JR., Tupelo. Born Evansville, Ind., Aug. 31, 1943; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1969; interned Baptist Memorial Hospital, Memphis, Tenn., one year; ophthalmology residency, University Medical Center, Jackson, Miss., 1970-74; elected by Northeast Mississippi Medical Society.

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

Jan. 27-31, 1975

EKG Intensive Course

University Medical Center, Jackson
Jan. 27-31, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
Thomas M. Blake, M.D., professor of medicine, the University of Mississippi School of Medicine

The course will consist of a series of discussions of selected topics in electrocardiography chosen on the basis of their immediate clinical applicability. Electrocardiograms, slides and other visual aids will be used, and participants will have the opportunity to interpret electrocardiograms, raise questions, and suggest specific topics for consideration. Interpretation of tracings will be emphasized.

Feb. 10-14, 1975

Urology Intensive Course

University Medical Center, Jackson
Feb. 10-14, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
W. Lamar Weems, M.D., associate professor of surgery and chief of the Division of Urology, the University of Mississippi School of Medicine

The course will emphasize practical urology as it relates to the non-urologist. The latest concepts and practices in common urologic diseases will be presented.

Feb. 17-21, 1975

Otolaryngology Intensive Course

University Medical Center, Jackson
Feb. 17-21, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
Godfrey E. Arnold, M.D., professor of surgery, director of the Division of Otolaryngology, and associate professor of physiology-biophysics, the University of Mississippi School of Medicine

This course will present a basic review of otolaryngology for the primary care physician, including office treatment, detection of complications, and overview of special services. This will include audiology, vestibular testing, speech and voice rehabilitation, allergies, and neurotology. Lectures, seminars, clinics, rounds, demonstrations, and surgical observations will be supplemented by assigned reading.

Feb. 24-28, 1975

Pediatrics Intensive Course

University Medical Center, Jackson
Feb. 24-28, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
J. M. Montalvo, M.D., professor of pediatrics and assistant professor of biochemistry, the University of Mississippi School of Medicine

Registrants will participate in intake and ward rounds, refresh their skills in such areas as scalp vein techniques, use of the respirator, nebulizer and humidifier, and attend lectures on such subjects as fluids, hematology, cardiology, immunizations, allergies, seizures, pediatric emergencies, pediatric surgery, renal problems, and the care of the newborn. Round table discussions will include pediatric problems.

Mar. 3-7, 1975

Hematology-Oncology Intensive Course

University Medical Center, Jackson
Mar. 3-7, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
Francis S. Morrison, M.D., associate professor of medicine and director of the Division of Hematology, the University of Mississippi School of Medicine

Recent advances in oncology, as well as the basics of diagnosis and therapy, will be presented. Supportive management such as advances in component and problems of infection in immunosuppressed patients will be emphasized. Newer developments in hematology will also be covered.

Mar. 13-15, 1975

SURGERY FORUM

The Jackson Hilton Hotel
Mar. 13-15, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education and the School of Medicine Department of Surgery

Coordinators:
James D. Hardy, M.D., professor of surgery and chairman of the department, the University of Mississippi School of Medicine
William O. Barnett, M.D., professor of surgery, the University of Mississippi School of Medicine

This second annual three-day surgery conference features latest advances in surgical procedures. Lectures will cover gastrointestinal, endocrine, colon, pancreas, and breast surgery. Attendance is by invitation, and advance registration with fee of $150.00 is required. The fee is refundable prior to Feb. 14, 1975.

Mar. 20-22, 1975

NEUROLOGY-NEUROSURGERY INTENSIVE COURSE

University Medical Center, Jackson
Mar. 20-22, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinators:
Robert D. Currier, M.D., professor of medicine (neurology) and chief of the Division of Neurology, the University of Mississippi School of Medicine
Glen C. Warren, M.D., assistant professor of neurosurgery, the University of Mississippi School of Medicine

This two-day course will be didactic in format with opportunities for the participants to discuss the problems primary care physicians most often encounter in their practices. Head injury, the dizzy patient, headaches, epilepsy, sciatica, strokes, and tumors will be discussed in relation to adult and pediatric neurology and neurosurgery.

Mar. 24-28, 1975

CARDIOLOGY INTENSIVE COURSE

University Medical Center
Mar. 24-28, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
James R. Galyean, M.D., assistant professor of medicine, the University of Mississippi School of Medicine

The course will familiarize physicians with current concepts in bedside diagnosis of heart disease. Practical points in physical diagnosis and in review of the various forms of heart disease will be covered using such aids as pulse tracings, phonocardiograms, electrocardiograms, x-rays, and hemodynamic data in illustration. Participants will round, observe cardiac catheterizations, and enter into team discussions on patient management. Reasons for suggesting or rejecting surgery will be discussed in detail. A cross-section of cardiac diagnoses will be reviewed.

All intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, pharmaceutical firms, volunteer health agencies, and private donation. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged for each.

FUTURE CALENDAR

Mar. 31-April 1, 1975

NEONATAL WORKSHOP

The Jackson Hilton Hotel
Mar. 31, April 1, 1975

Sponsored by the University of Mississippi Medical Center Division of Newborn Medicine,

the American College of Nurse-Midwives, and Meade Johnson

May

FAMILY PRACTICE REVIEW

May 5-8

MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

Spring

RENAL SEMINAR

Fall

DIABETES SEMINAR

AMA Urges Caution In Prescribing Drugs

The American Medical Association has urged physicians to exercise great caution in prescribing sleeping pills and tranquilizers that might lead to drug abuse and addiction.

"Because of the proliferation of psychoactive substances, the physician, today more than ever before, should guard against contributing to drug abuse through injudicious prescription practices or by acquiescence to the demand of some patients for instant chemical answers to their problems," the AMA declared.

The physician should first determine that there are sound medical indications for using a psychoactive drug, such as a sleeping pill or a tranquilizer. He should then weigh three additional factors: (1) The severity of symptoms in terms of the patient's ability to accommodate them, (2) The patient's reliability as a drug taker, noted through observation and careful history taking, and (3) The dependence liability of the drug itself.

The AMA listed 10 "points to remember" for physicians when administering or prescribing these products:

1. Use barbiturates and other sedative-hypnotics for relief of severe symptoms, but avoid them for minor complaints of distress or discomfort.

2. Attempt to diagnose and treat underlying disorders before relying on drugs of this class for symptomatic relief.

3. Assess susceptibility of the patient to drug abuse before prescribing barbiturates or any other psychoactive drugs. Weigh benefits against hazards.

4. Use dosages that will not lower sensory perception, responsiveness to the environment, or alertness below safe levels.

5. Know how to administer barbiturates when clinically indicated for withdrawal in cases of drug dependence of the barbiturate type.

6. Using periodic checkups and family consultations, monitor possible development of dependence in patients who are on an extended sedative-hypnotic regimen.

7. Prescribe no greater quantity of a drug than is needed until the next checkup.

8. Warn patients to avoid possible adverse effects because of interaction with other drugs, including alcohol.

9. Counsel patients as to the proper use of medication—follow directions on the label, dispose of old medicine no longer needed, keep medicine out of reach of children, do not "share" prescription drugs with others.

10. Convey to patients through your own attitude and manner that drugs, no matter how helpful, are only one part of an overall plan of treatment and management.

The statement was prepared by the AMA Committee on Alcoholism and Drug Dependence, and approved by the AMA Council on Mental Health and the AMA Department of Drugs.

Hair Transplant Symposium Scheduled

The American Society for Dermatologic Surgery and The American Academy of Facial Plastic and Reconstructive Surgery, Inc., are co-sponsoring the second annual Hair Transplant Conference which is designed to offer an opportunity for the exchange of ideas among various disciplines and to present the latest advances in techniques on hair transplantation.

The symposium will be held Feb. 14-15, 1975, at the Stough Dermatology and Cutaneous Surgery Clinic, P. A., Hot Springs, Ark.

Attendance will be limited. Faculty will include dermatologists, otolaryngologists, regional and general plastic surgeons.

For further information, contact: Dr. D. B. Stough, III, Program Director, Doctors Park, Hot Springs, Ark. 71901.

Book Review

General Pathology. 4th Edition. By J. B. Walter, T.D., M.D., M.R.C.P., F.R.C. Path., and M. S. Israel, M.B., M.R.C.P., M.R.C. Path., D.C.P. 681 Pages. Edinburgh and London: Churchill Livingstone, 1974. $32.50.

This textbook of general pathology will be useful to the student and to the physician practicing in all branches of medicine as well as to the practicing pathologist.

It is well organized, comprehensive, readable and well illustrated. It is large and moderately heavy but not ponderous.

The chapters on the normal cell, the cause of disease and the inflammatory reaction have been expanded and updated to include electron microscopy, cell reproduction, the fine structure of the cell and genetic abnormalities.

The section on immunology is particularly good and some 75 pages are devoted to the basics of the immune response, the antibody forming tissues, immunity to infection, hypersensitivity and the graft reaction. Those who have explored the recent literature on these subjects will appreciate the clear review of the basic theories of immunity given by the authors. Following this section there is a comprehensive discussion of diseases mediated by immunological mechanisms.

The section on virology is comprehensive and elementary, references are up to date and complete.

This is no text of detailed morbid anatomy and the practicing pathologist will not find an answer to his problem case. If he is seeking correlation of the basic pathological processes with the disciplines of biochemistry, physiology and clinical medicine, this text will be useful.

THOMAS F. PUCKETT, M.D.
Hattiesburg, Miss.

State Drug Treatment Resources Listed

Mississippi offers a variety of drug treatment resources within the state. These include detoxification, counseling, and referral services.

Crossroads Services, Inc. in Jackson is a multimodality treatment and rehabilitation program. The center is structured around a concept of comprehensive and continuing care for persons with drug or drug-related problems with special attention given to the young polydrug user. Programs include various educational workshops for teachers, parents, and civic groups. Crossroads offers residential and outpatient services, such as individual and group counseling, detoxification, job placement and development, follow-up care and referral services. For more information, contact Executive Director Charlene Andrews at 969-6969.

Mississippi State Hospital at Whitfield and East Mississippi State Hospital at Meridian provide a full range of services to persons with all types of mental health problems, including drug misuse. The treatment for drug misuse is an undifferentiated part of the service delivery systems of the hospitals. First time drug offenders are sent to either hospital by chancellors' decree.

Services offered by the state hospital at Whitfield, which has a 4,700 bed capacity, include detoxification, post emergency care for drug intoxifications, hospitalization, counseling and other supportive services. Dr. W. L. Jaquith, Administrator, can be reached at 939-1221.

Services offered by East Mississippi State Hospital at Meridian, which has a 1,000 bed capacity, include detoxification, methadone maintenance or other types of chemotherapy, post emergency care for drug intoxifications, hospitalization, milieu therapy, educational services, counseling and other supportive services. Dr. James Champion, Director, can be reached at 482-6186.

The Community Mental Health Centers throughout the state offer drug treatment services, mostly in the form of counseling and referrals. However, Pine Belt Mental Health Center in Hattiesburg, Gulf Coast Mental Health Center in Gulfport, North Mississippi Mental Health Center in Tupelo, and Weems Community Mental Health Center in Meridian offer detoxification services through the state hospitals or through local hospitals. Mental health centers offering drug treatment services other than detox are Jackson Mental Health Center, Southwest Mississippi Mental Health Center in Brookhaven, Comprehensive Mental Health Center in Clarksdale, Re-

gional Mental Health and Mental Retardation Center in Oxford, Delta Community Mental Health Services in Greenville, and Region 6 Community Mental Health-Retardation Center in Greenwood.

The Youth Crisis Center in Jackson is a counseling and crisis walk-in center for young people through the age of 21. Besides providing individual and group counseling, inpatient services, medical and legal services, the center is open 24 hours a day to handle emergencies. Executive Director Harry Hughes can be reached at 355-3070.

The Catacombs in Gulfport is a non-residential center (although the Gulf Coast Mental Health Center will provide beds for Catacomb clients at Gulfport Memorial Hospital) where therapy is based upon "people problems" instead of drug problems. In this way an attempt is made through group, individual and family counseling to help the drug misuser obtain better insight into himself and the underlying causes of his drug problem. Psychiatric and medical services are also offered. One can reach Acting Director Dr. Roger Fox at 863-6958.

Shady Oaks in Pascagoula is a rap house where persons with drug or drug-related problems come together for mutual support. It offers a limited structured therapy to enable each person involved to realize his inner potential for discovering a self-reliant life without drug usage. Professional consultants for Shady Oaks are Wayne Brown, Steve Bollinger, and Wanda Coniaus.

In addition to drug treatment centers, several cities offer a telephone "Hotline" service which offers help to individuals 24 hours a day, 7 days a week. This service provides information and referrals for a variety of personal problems. The personnel manning these lines are trained and equipped to cope primarily with crisis or emergency situations. These "Hotlines" are "Help Line" in Vicksburg, "Help Anonymous" in Greenwood, "Listening Post" in Meridian, "Contact" in Jackson, "Project Help" in Starkville, "Rap Line" in Oxford, "Service Central" in Hattiesburg, "Help Anonymous" in Indianola, "Help Line" in Ocean Springs, and the Catacombs "Hotline" in Gulfport.

(From the Mississippi Clearinghouse for Drug Misuse Information, 1001 Lee State Office Building, Jackson, Miss. 39201.)

Dr. Zollinger Headlines Surgical Forum

Dr. Robert M. Zollinger, professor of surgery and chairman of the department emeritus at the Ohio State University College of Medicine, is one of 11 internationally known surgeons on program for the second annual postgraduate surgical forum at the University of Mississippi Medical Center in Jackson.

To be held Mar. 13-15, the conference will focus on recent advances in gastrointestinal, endocrine, colon, pancreas, and breast surgery.

Other guest participants include Dr. Isidore Cohn, professor of surgery and chairman of the department, Louisiana State University School of Medicine, New Orleans; Dr. Theodore Drapanas, professor of surgery and chairman of the department, Tulane University School of Medicine, New Orleans; Dr. Stanley J. Dudrick, professor of surgery and chairman of the department, University of Texas Medical School, Houston; Dr. Richard H. Egdahl, professor of surgery at Boston University School of Medicine, Boston; Dr. John M. Howard, Crozer-Chester Medical Center, Upland, Chester, Pa.; Dr. Francis Moore, Moseley professor of surgery, Harvard Medical School, Boston; Dr. H. William Scott, Jr., professor of surgery and chairman of the department, Vanderbilt University School of Medicine, Nashville, Tenn.; Dr. Colin G. Thomas, Jr., professor of surgery and chairman of the department, University of North Carolina School of Medicine, Chapel Hill; Dr. R. B. Turnbull, head of the department of colon and rectal surgery, The Clinic Center, Cleveland; and Dr. Claude Welch, clinical professor of surgery emeritus, Harvard Medical School, Boston.

Advance registration with $150.00 fee should be addressed to the Division of Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, Miss. 39216.

Psychiatric Grants Go to Schools

Twenty-six psychiatric nursing training grants totalling more than $2 million have been awarded to schools throughout the U. S. and the Virgin Islands by the National Institute of Mental Health of HEW's Alcohol, Drug Abuse, and Mental Health Administration. The University of Southern Mississippi at Hattiesburg received $89,132.

The grants will support both graduate and undergraduate training in mental health. Primary emphasis will be on the development of skills needed in caring for persons with psycho-social problems. Special projects will be directed at providing training relevant to treating children, the aged, and disadvantaged persons in rural and poverty areas.

MSMA Board of Trustees Holds Fall Meeting

The MSMA Board of Trustees held its regular fall meeting on Dec. 5, 1974, in Jackson. Primary business coming before the Board and General Officers of the association were reports from the Councils on Legislation and Budget and Finance.

The Board reviewed the association's 1975 legislative program to include proposals to increase professional fees authorized under Medicaid in 1969 based on cost-of-living increases, to authorize the State Board of Health to authorize and certify the use of physician assistants as described by his physician employer, to authorize a 28-day life span for CPD preserved blood, to modernize the state's commitment procedures for the mentally ill, and to set standards for HMOs. The Board also considered prefiled legislative proposals to require annual registration of physician licenses and requested the Council on Legislation to strongly indicate the profession's concern that such legislation require annual registration only at a fee to be set by the State Board of Health and not to exceed $10.00.

The Council on Budget and Finance recommended and the Board approved a 1975 association budget of $246,701. The budget continues MSMA staff at its 1970 total.

In other business the Board reviewed the status of proposed legal action against Mississippi chiropractors and directed that the matter be brought to the attention of the House of Delegates at the 1975 Annual Session. The Board also considered the status of physician assistants in Mississippi and directed that the association join the Mississippi State Board of Health in clarifying the legal and ethical relationship of physician assistants to their physician employers.

The Board also heard reports on the status of the association's group insurance programs and implementation of the new uniform health insurance claim form. Based on Board action, the association will organize and offer peer review to those physicians receiving more than $100,000 annually from the Mississippi Medicaid Program. A report from the Committee to Study Component Medical Society Organization and Compensation of Elected Officers was received for information and the Board directed the staff to work with interested organizations in arranging a MSMA member and family chartered flight to the AMA Clinical Session in Hawaii next December. The next meeting of the Board was set for Mar. 27, 1975, in Jackson.

Rankin General Opens Adolescent Unit

Rankin General Hospital at Brandon announces the opening of an 18-bed unit inpatient psychiatric facility for adolescents (ages 13-17).

Patients first undergo an evaluation period of 5-7 days which includes a thorough physical, mental, emotional, developmental, educational and behavioral assessment, according to Dr. C. Mims Edwards, Medical Advisor. At the end of the evaluation period, there is a staff meeting to further develop the treatment plan and make appropriate recommendations. Referral sources are included in the planning and a conference is held with the patient's family after the staff meeting.

The facility is planned for treatment up to a four month period. Services provided are individual therapy, group therapy, recreational/occupational therapy, educational therapy, parental counseling, social service and a behavior modification program.

The evaluation/treatment program is accomplished by a staff of registered nurses, licensed practical nurses, an educational psychologist (Ph.D.), social worker, clinical adolescent specialist, recreational/occupational therapist, driver-attendants, secretary and Dr. Edwards. All services provided by the general hospital are also available to the adolescent unit.

Potential admissions are evaluated by an in-take committee with the final decision left up to the Medical Advisor. There is some selection of patients; however, there is potential for maximum control in two of the rooms. Selection of patients is based on capability of managing the whole unit as the staff can control only a small percentage of severely disturbed patients, said Dr. Edwards. When drug abuse is the prominent problem, patients are accepted for admission after they have been treated in a specialized drug program.

Dr. Edwards is a board qualified psychiatrist who has limited his practice to adolescent inpatients. His office is in the unit at 350 Crossgates Boulevard in Brandon.

Rankin General Hospital is approved by the Joint Commission on Accreditation of Hospitals and is licensed by the Mississippi State Commission on Hospital Care.

State Physicians Take Intensive Courses



Primary care physicians in the hematology-oncology intensive course at the University of Mississippi Medical Center discussed recent advances in oncology, as well as the basics of diagnosis and therapy, and newer developments in hematology. Among participants were, from left, Dr. Charles A. Hollingshead and Dr. James C. Waites of Laurel, and Dr. Wendell N. Gilbert of York, Ala. The UMC Division of Continuing Health Professional Education will again offer the course Mar. 3-7, 1975. Mississippi Regional Medical Program partially supports these intensive courses.

Dr. Blair Batson Named to AAP Office

Dr. Blair E. Batson, M.D., professor and chairman, Department of Pediatrics, University of Mississippi School of Medicine, became the new chairman for District VII at the American Academy of Pediatrics annual meeting.

Dr. Batson's medical career has included active involvement in academy work on both the national and state levels. He is presently a member of the AAP Nominating Committee. He is a charter member of the Section on Child Development and of the Section on Public Health, presently serving on that section's nominating committee.

He was a member of the Mead Johnson Research Awards Committee (1958-61) and of the Committee on Hospital Care (1970-73). Dr. Batson served

as a medical consultant to the AAP Head Start Medical Consultation Program (1968-72).

On the state level, Dr. Batson is a member of the Mississippi Chapter and has served on its executive committee since 1962.

Dr. Batson received his A.B. degree from Vanderbilt University in 1941 and his M.D. in 1944. Ten years later he earned an M.P.H. degree from Johns Hopkins University School of Medicine.

He came to Mississippi in 1955, becoming professor and chairman of the Department of Pediatrics, University of Mississippi School of Medicine.

Dr. Batson has held numerous positions in medical activities at all levels. He is a trustee of the Easter Seal Foundation; national consultant in pediatrics to the United States Air Force; member of the Mississippi Governor's Committee on Children and Youth, serving as chairman of the subcommittee on health. He is an examiner for the American Board of Pediatrics. He is a member of Central Medical Society, MSMA and AMA.

District VII includes the states of Alabama, Arkansas, Louisiana, Mississippi, Oklahoma and Texas.

Dr. Dewey Lane Will Head Economic Council

Dr. Dewey H. Lane, Jr., of Pascagoula has been elected president-elect of the Mississippi Economic Council. He will serve as MEC president in 1975-76.

Dr. Lane has long been active in MEC, having most recently served as chairman of the education committee.

In other areas of community service, Dr. Lane was president of the Board of Trustees of the Pascagoula Municipal Separate School District in 1973. In 1969 he was named Pascagoula's Outstanding Young Man and received the Distinguished Service Award of the Pascagoula Jaycees and went on to be named Jackson County's Outstanding Citizen.

Dr. Lane has served as a director of the Pascagoula-Moss Point Area Chamber of Commerce and is also on the board of directors of the Jackson County Mental Health Association. He is active in the Mississippi Republican Party.

The general surgeon has practiced in Pascagoula since 1964. He graduated from Tulane School of Medicine, interned at Charity Hospital in New Orleans and completed residency training at Tulane.

Dr. Lane is a member of Singing River Medical Society and the Mississippi State Medical Association. He has also served as chief of staff at Singing River Hospital.

UMC Continuing Education Receives Gift

The Division of Continuing Health Professional Education at the University of Mississippi Medical Center has received a $9,000 gift from the L. W. and Dannie T. Brock Scholarship Fund.

The fund was established in 1969 by the McComb Infirmary Association in honor of the late Dr. L. W. Brock and Mrs. Dannie T. Brock.

Dr. Ralph L. Brock, spokesman for the association and son of the late Dr. Brock, said the gift is in keeping with his father's "abiding interest in continuing education" for health professionals.

The late Dr. Brock, the son of a physician, began his practice with his father in Mt. Herman, La., in 1911. He moved to McComb in 1925 and 10 years later purchased the McComb Infirmary which he managed until his death in 1964.

Three sons—Dr. Jep S. Brock, dentist; Dr. Jim M. Brock, dermatologist; and Dr. Ralph Brock, family practitioner—all practice in McComb.

Dr. Ronald B. Robertson, director of continuing education at UMC, said the contribution will be used to assist and expand the continuing education program.

"Continuing education improves the quality of health care for everyone, so this is really a gift to all Mississippians," he said.

Pediatric Chest Radiology Course Set

The Institute for Pediatric Radiology and Dr. Charles E. Shopfner will present a postgraduate course entitled "Current Status of Pediatric Chest Radiology," Feb. 22-23, 1975, at the Marriott Hotel in New Orleans.

This intensive course in radiological procedure and diagnosis is designed to meet the needs of family physicians, pediatricians and radiologists.

The course is approved by the American Medical Association for Category 1 of the Physician's Recognition Award, Continuing Medical Education for 13 credit hours.

For additional information write: Institute for Pediatric Radiology, 4148 North Cleveland Avenue, Kansas City, MO 64117.

Local Ob-Gyn Workshops Offered by UMC Faculty

Improved care for Mississippi mothers and babies is the goal of workshops planned for six hospitals throughout the state this year.

University of Mississippi Medical Center faculty will conduct the workshops on request. A grant from the American College of Obstetricians and Gynecologists supports the program for the second year. Last year, faculty from the UMC departments of obstetrics and gynecology and family medicine went to hospitals in Tupelo, Starkville and Laurel.

"Response was excellent so we're doubling the number of workshops this year," says Dr. Donald Sherline, UMC professor of ob-gyn and program coordinator.

Local participants choose workshop subjects, and Dr. Sherline says, "We're ready to talk about any problem which community health professionals feel is pertinent to their patients."

The one-day classes are free to any worker on the health care team interested in the workshop topic. Family physicians who attend get six hours of postgraduate credit from the American Academy of Family Physicians.

Additional information can be obtained from the Division of Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, Miss. 39216.

Dr. J. T. Davis Visits West Miss. Medical Society



Dr. J. T. Davis of Corinth, president of MSMA, was special guest at the recent installation meeting of the West Mississippi Medical Society held in Vicksburg. At left is Dr. A. J. Messina, Warren County health officer, and at right is Dr. Tom Mitchell, WMMS state delegate.

Miss Cleta Brinson Retires From SBH

Miss Cleta Brinson, executive secretary to the State Health Officer for 34 years, has retired. She was honored with a reception in the SBH auditorium.

"Miss Cleta" is familiar to MSMA members as the official recorder of the House of Delegates. In this capacity she has sat on the podium at meetings of the House for the past 23 years.



Miss Brinson

Miss Brinson came to the State Board of Health to work in the medical library in 1940 and in three years was made executive secretary to Dr. Felix J. Underwood. Since then she has served as executive secretary to three more State Health Officers: Drs. Archie L. Gray, Hugh Cottrell and Alton B. Cobb.

One of her most memorable experiences with the organization was the 1973 Oriental Workshop Tour sponsored by the American Public Health Association's southern branch. The 25,500 mile tour included visits to Hawaii, Tokyo, Hong Kong and Australia.

Miss Brinson has received numerous honors for her work in the public health field. In 1969 she was elected president of the Mississippi Public Health Association. She is also listed in *Who's Who in American Women*.

Originally from Monticello, Miss Brinson was reared at Clarksdale and was graduated from Mississippi University for Women with a B.A. in mathematics.

History of Medicine Society Meets

The History of Medicine Society held a business meeting and elected officers on Nov. 13 at the University Medical Center in Jackson.

Dr. John Gibson, president, presented a review of past achievements, a report of current status and recommendations for the future.

Dr. Gibson was named to a third term as president. Other officers elected were Dr. Ojus Malphurs,

first vice president; Dr. James P. Spell, second vice president; Dr. J. W. Laing, secretary-treasurer; and Mr. Jud Farmer, librarian.

Dues were increased to $10.00 annually for single or family membership and meetings were reduced to twice a year. The next dinner meeting will be in February or March and Dr. Jose Bebin, neuropathologist, will be speaker.

Possible new projects discussed included a museum case for medical relics to be placed at UMC and periodical articles on medical history to be published in the JOURNAL MSMA under "Historical Notes."

For further information, contact Dr. John Gibson, Department of Radiology, UMC, 2500 N. State St., Jackson 39216.

Johnson Foundation Funds Primary Care Services

The Robert Wood Johnson Foundation is establishing a $30 million, four year grant program to expand primary medical care services in community hospitals.

About 60 hospitals will be selected with at least one hospital in every state receiving up to $500,000 for the four year program scheduled to start in 1976. Invitations to apply went out to about 900 nonprofit hospitals according to a foundation spokesman.

The program's goal is to have groups of three or more fulltime physicians offering around-the-clock primary care. These physician groups could be based either in the sponsoring hospital or in separate facilities.

"Community hospitals are a major focus for medical care but their emergency rooms and outpatient departments are having increasing difficulty meeting service demands being placed on them as substitutes for the doctor's office," Dr. David E. Rogers, foundation president, said.

The program will also provide professional opportunities for the increasing number of young physicians in primary care, he said. "We hope these community hospitals will demonstrate how group practices can offer stable, professionally satisfying opportunities that can enhance a community's ability to attract and hold new physicians."

Ultimately, the program hopes that each primary medical care group will be able to serve at least 15,000 people. The National Planning Association, a nonprofit research group in Washington, D. C., is administering the program.

Nephrology Course Held at Medical Center



Twelve primary care physicians who took the one-week intensive course in nephrology at the University of Mississippi Medical Center included, seated, from left: Dr. Thomas Whitehead, Columbia, and Dr. Thomas Howell, Laurel; standing, from left: Dr. Elmo Gabbert, Meadville; Dr. Karl Horn, Moss Point; Dr. W. B. Larkin, Bude; Dr. Jerry Welch, Laurel; and Dr. Gordon McHenry, Wiggins. Other participants were Dr. Robert Coghlan of Aberdeen; Dr. P. Temple Carney of York, Ala.; Dr. Robert Ireland of Clinton; Dr. Jack Whites of Birmingham, Ala.; and Dr. Francis Selman, Jr., of Pascagoula. The UMC Division of Continuing Health Professional Education sponsored the course with partial support from Mississippi Regional Medical Program. Emphasizing the reversible and treatable forms of renal disease, the course will be offered again April 14-18, 1975.

Summer Scholarships Provided by MLA

For the third consecutive year, the Mississippi Lung Association has awarded summer scholarships to six Mississippi medical students. This technical and financial aid, sponsored by the Christmas Seal voluntary health organization, issues a challenge to encourage advanced education in pulmonary medicine.

Dr. Guy Campbell, Chief of Pulmonary Disease Section, Veterans Administration Hospital, associate professor at the University of Mississippi School of Medicine and MLA Board Member, directed three externs at the VA Hospital. Dr. Joe Norman, professor of medicine, Christmas Seal Professor of Pul-

monary Disease, Director of Pulmonary Division and associate professor of physiology-biophysics at the University of Mississippi School of Medicine, directed three of the scholarship recipients at the University School of Medicine.

Externs receiving the merit-awarded scholarships were: George Bush, son of Mr. and Mrs. Ford C. Bryant of Hattiesburg; David McGraw, son of Mr. and Mrs. H. Burnell McGraw of Woodville; Bill Sneed, son of Dr. and Mrs. Ralph Sneed of Jackson; Bill Strong, son of Mr. and Mrs. W. B. Strong, Sr., of Vicksburg; John Studdard, son of Mr. and Mrs. W. E. Studdard of Jackson; and Max Taylor, Jr., son of Mr. and Mrs. Max Robert Taylor, Sr., of Whitfield.

Judson M. Allred, Jr., Executive Director of the Mississippi Lung Association, notes that the rewards of this program lie in the future for pulmonary patients. The goal of the Mississippi Lung Association is to prevent and control diseases of the lung and the adoption of the summer scholarship program is a forward step toward that aim.



Six summer scholarships to medical students were provided by the Mississippi Lung Association to advance education in pulmonary medicine. Dr. Joe R. Norman (left), Christmas Seal Professor and Director of Pulmonary Division, University of Mississippi School of Medicine, directed externs (seated from left) George Bush and David McGraw. Dr. Guy Campbell (far right), VA Hospital Chief of Pulmonary Disease and MLA Board Member, supervised (standing) Max Taylor, Jr., John Studdard and Bill Sneed at the Veterans Hospital.

Heart Disease Studied at UMC



Current concepts in bedside diagnosis of heart disease were featured in the fall cardiology intensive course at the University of Mississippi Medical Center. Participants included, from left, Dr. P. Temple Carney of York, Ala.; Dr. Harry G. Causey and Dr. N. E. Murillo Smith, both of Meridian. The UMC Division of Continuing Health Professional Education will repeat the course Mar. 24-28, 1975, with partial support from Mississippi Regional Medical Program. Advance registration is required for the one-week intensive courses.

MPAC Supports Trent Lott



Dr. Jack C. Hoover of Pascagoula, at left, and Dr. W. W. Walley of Waynesboro, right, members of the Miss. Medical Political Action Committee's Board of Directors, are shown presenting the MPAC contribution to Congressman Trent Lott.

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

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Emergency Care Course Scheduled

An Emergency Room Medical-Surgical Care course will be sponsored by The Alton Ochsner Medical Foundation, Charity Hospital, LSU School of Medicine and Tulane will be held April 7-19 at the Ochsner Foundation Hospital in New Orleans.

The two week course will be of the lecture-preceptor type and registration is limited to 14. Fee is $400.00. The American College of Emergency Physicians has granted 96 hours credit toward its continuing medical education requirements.

Direct all inquiries to: Division of Education, Ochsner Medical Foundation, 1514 Jefferson Highway, New Orleans 70121.

Aspen Radiology Conference Scheduled

The Fifth Annual Aspen Radiology Conference will be held March 3-7, 1975, at the Aspen Institute for Humanistic Studies, Aspen, Colorado.

The conference is designed for physicians and scientists interested in diagnostic radiology, nuclear medicine and radiation therapy and will explore the impact of clinical and technological advances on radiologic practice.

The topics for discussions will include advances in bone, vascular, gastrointestinal, and neuroradiology involving a tri-radiological approach. Each morning will survey the advances in a single radiology subdivision as a refresher course with independent diagnostic, nuclear medicine and therapy sessons. Previewed instructive cases, illustrating these topics, will be presented for open discussion in the afternoons.

Further information may be obtained from Dr. Maurice O'Connor, Conference Director, Division of Radiology, Denver General Hospital, Denver, Col. 80204.

JOIN MPAC TODAY

International Academy of Pathology Meets

The 64th annual meeting of the International Academy of Pathology will be held at the Marriott Hotel in New Orleans, from Tuesday evening, March 4 through Saturday, March 8, 1975.

The annual Maude Abbott Lecture entitled "Pathology and Preventive Medicine" will be delivered on Wednesday by Dr. John Higginson, director, International Agency for Research on Cancer, Lyon, France.

Eighty scientific papers, 6 pathology specialty conferences, 48 Short Courses, a seminar on Techniques for Tissue Pathology, a special course on Electronmicroscopy, and the Long Course on Diseases of Bones and Joints directed by Dr. Lauren V. Ackerman and Dr. Harlan J. Spjut will be given during the meeting.

Further information may be obtained from Dr. Leland D. Stoddard, Secretary-Treasurer, U. S.-Canadian Division, International Academy of Pathology, Department of Pathology, Medical College of Georgia, Augusta, Ga. 30902. Telephone (404) 722-1111.

Information about Short Courses, the EM Course and the Long Course may be obtained from Mrs. J. Preston, IAP Registrar, Armed Forces Institute of Pathology, Room 4090, Washington, D. C. 20306. Telephone (202) 576-2969.

Hattiesburg Clinic Is Being Expanded

The Hattiesburg Clinic on South 28th Avenue in Hattiesburg is involved in an extensive construction and remodeling program, including a four-story addition.

The four new floors will be constructed above part of the original building in a "tower" fashion, with new clinical spaces and waiting rooms throughout. Each floor will add 7,500 square feet of space and will be serviced by elevators and staircases.

The front entrance to the clinic will be moved from its present location on the east side to the south side of the building. This will allow better access to the various medical departments and greater accessibility to parking areas, a spokesman for the clinic said.

New heating and air conditioning systems will be installed and the first floor will be totally remodeled. X-ray and laboratory facilities will be doubled and tripled in size, respectively, and other ancillary services will be added.

The Hattiesburg Clinic presently is composed of 23 fulltime physicians covering 10 specialties and subspecialties, with consulting radiologists and pathologists.

It is anticipated that the building will be completed by September 1975.



This is the artist's conception of the Hattiesburg Clinic upon completion of construction.

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

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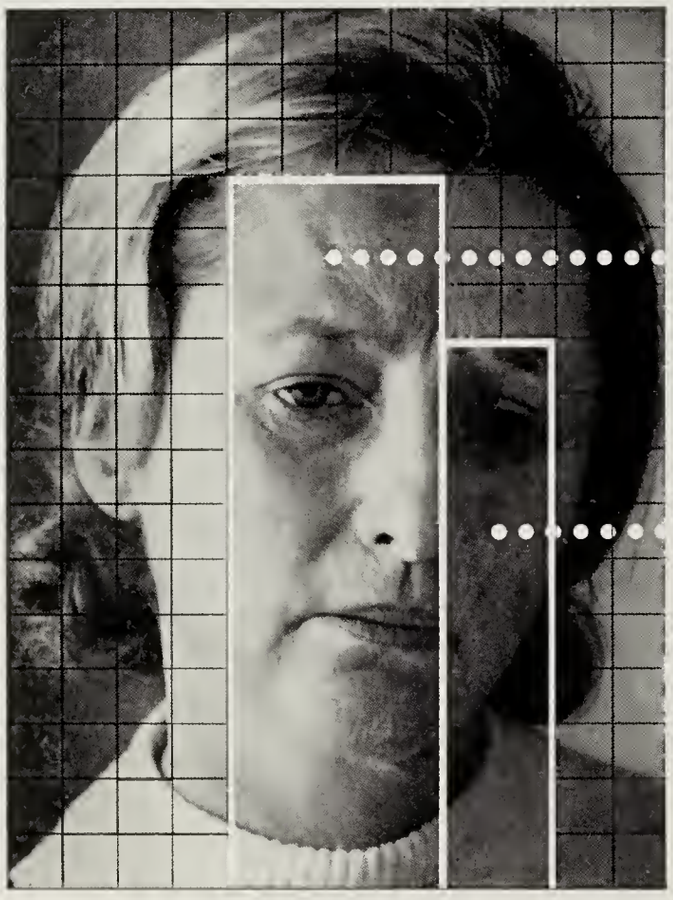
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This Month . . . Ischemic Colitis, Hallucinogenic Mushrooms, Gonorrhea, Recurrent Postgastrectomy Gastric Bezoar

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
February 1975, Vol. XVI, No. 2

ORIGINAL PAPERS

Ischemic Colitis

BILL W. LONG, M.D., and
C. JAY KEES, M.D.,
Jackson, Mississippi

Ischemic colitis is a recently recognized syndrome with varying degrees of colon injury, depending on the severity of the compromised blood flow to the bowel, say the authors, a radiologist and a medicine resident. They give an illustrative case report and discuss the clinical and radiographic manifestations.

ISCHEMIC COLITIS is a recently recognized syndrome with varying degrees of colon injury, depending on the severity of the compromised blood flow to the bowel. We suggest that ischemia of the colon occurs in the same age group and from the same causes as myocardial infarction. Three distinct clinical syndromes have been described. A case is reported and clinical as well as radiographic manifestations are discussed.

CASE REPORT

On March 6, 1974, a 64-year-old man came to the Jackson V.A. Hospital emergency room with a 48-hour history of the sudden onset of severe cramping, lower abdominal pain and with a 24-hour history of bright red rectal bleeding. He had experienced six bowel movements associated with bloody diarrhea on the day of admission. He gave no history of gastrointestinal or cardiovascular difficulties. The only pertinent physical findings were bilateral lower abdominal tenderness and bright red blood in the rectal vault. His admission laboratory data was within normal limits. His hematocrit reading was 40 per cent. An electrocardiogram demonstrated the presence of a right bundle branch block. Proctoscopy to 25 cm. was normal. A barium enema the following day revealed an area of narrowing, submucosal edema, and "thumbprinting" in the distal 12-14 inches of the transverse colon (see Figure 1). This was felt to be diagnostic for ischemic colitis, without full-thickness involvement. An abdominal aortogram demonstrated normal mesenteric vessels.

It was decided to treat this patient conservatively with intravenous fluids, clear liquid diet, oral neomycin and intravenous Keflin to guard against sepsis. The bloody diarrhea stopped within 36 hours. Within one week, he was free of abdominal pain. A repeat barium enema on March 18, 1974, was within normal limits (see Figure 2).

DISCUSSION

Only in the past decade has ischemic colitis emerged as a distinct clinicopathologic entity. Three quite different clinical syndromes have been described (Marston, et al),[1] depending upon (1) the extent of the vascular occlusion, (2) the duration of the occlusion, (3) the efficiency of the collateral circulation, and (4) the extent of secondary bacterial invasion.

First, *gangrenous ischemic colitis* (Group I) occurs when there is complete loss of arterial flow with

From the Departments of Medicine (Dr. Long) and Radiology (Dr. Kees), University of Mississippi Medical Center, Jackson, Miss.

subsequent full thickness infarction and gangrene. If untreated, colonic perforation with peritonitis and death results. Secondly, *stricturing ischemic colitis* (Group II) occurs when gross impairment of arterial supply results in hemorrhagic infarction of the mucosa, which ulcerates and allows bacterial invasion. Healing is by fibrosis, which often produces stenosis. Thirdly, *transient ischemic colitis* (Group III) results from transitory impairment of arterial supply which is soon compensated by collateral flow. There is a partial mucosal slough that is healed by mucosal regeneration within two or three days.[1, 2]

Early reports stressed that the splenic flexure is the most vulnerable segment, presumably because this is the area at the periphery of both superior and inferior mesenteric artery supply. Also, in this area the marginal artery of Drummond is at its greatest distance from the bowel wall. It is now clear, however, that ischemic colitis can affect any segment from the cecum to the rectosigmoid.

Major vascular occlusion usually does not correlate with ischemic colitis. Experimentally, ligation of the mesenteric artery in dogs has no deleterious effect on the colon; however, when the small vessels between the mesenteric arcade and the bowel are ligated, colonic ischemia is produced. In clinical practice mesenteric ischemia in general can either be occlusive or non-occlusive, a fact which is well documented in the literature.

Most patients with ischemic colitis are in the older age group and the majority have associated medical problems such as cardiovascular disease, rheumatoid arthritis or diabetes.

The onset of ischemic colitis is characteristically acute with mild to moderate generalized or lower abdominal cramping pain followed by passage of blood per rectum. Further symptoms depend on which of the three types of ischemic colitis is developing. In the gangrenous type, systemic symptoms of an abdominal catastrophe ensue. Barium enema is contraindicated and arteriography is unnecessary and delays proper treatment. Emergency operation as soon as the patient is stable is the proper course.



Figure 1. B. E. on March 7, 1974, with mucosal edema, thumbprinting (as if the margin of the bowel is indented), and narrowing of distal transverse colon.



Figure 2. B. E. on March 18, 1974, with resolution of findings.



Figure 3. Another patient with segmental colitis of distal transverse colon with narrowing and fine ulceration.

Conservative therapy is indicated in the latter two types, although the strictured colon should be electively resected with primary anastomosis if obstructive. Followup barium enemas will guide proper treatment. Recurrent episodes of ischemic colitis may occur. Early recognition and diagnosis are imperative for proper management of this disorder. This discussion primarily relates to non-gangrenous ischemic colitis, at least at the clinical onset, which includes Groups II and III (Marston).[1] Of course, from a single clinical or radiologic evaluation one cannot absolutely differentiate gangrenous from non-gangrenous or reversible from irreversible ischemic colitis.[3]

Infarction of the colon tends to be hemorrhagic which is the cause of the most important radiographic finding early after the insult, "thumbprinting" or pseudotumors on barium enema examination.

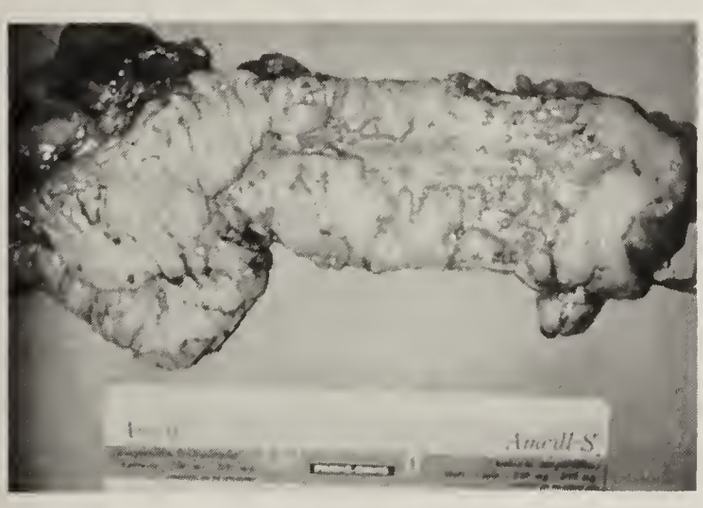


Figure 4. Same patient as Figure 3—path specimen with mucosal ulceration and edema.

The barium examination should be performed within 48 hours of the onset of symptoms since resolution of the hemorrhage can occur as early as two days.[4] As a matter of fact, persistence of "thumbprinting" beyond one week should make one suspect other causes.[3] Contrariwise, if the examination is performed after resolution of the "thumbprinting" the differential diagnosis may be more difficult.

Depending on the severity of infarction the colon can either return to normal or develop a segmental colitis pattern. Therefore, mild cases of reversible colitis develop "thumbprinting" with conversion to normal barium enema examination in one to two



Figure 5. Another patient with stricture of proximal descending colon and "sacculation."

weeks (as in the case reported herein). Other patients develop varying degrees of "segmental colitis" with fine ulceration and irregularity (see Figures 3 and 4) of the involved colon and may require one to six months of followup to establish the exact fate of the lesion.[3] Some of these may eventually resolve completely while others develop varying degrees of concentric and eccentric stricture disease. The latter results in another fairly characteristic sign, "sacculation" (see Figure 5). The decision on surgery will then depend on whether or not the stricture produces intestinal obstruction.

Therefore, characteristic enema findings include:

(1) thumbprinting—early after onset.
(2) colitis with fine ulceration—after a few days.
(3) sacculation
(4) stricture
} later after healing with fibrosis.

With these characteristic findings properly related temporally, especially if in the splenic flexure area, and with the correct clinical setting the diagnosis of non-gangrenous ischemic colitis is essentially certain.

Most cases of *spontaneous* ischemic colitis are non-gangrenous,[5] but a few of the patients upon follow-up will develop gangrene. Radiographic findings which can indicate this ominous occurrence are dilation (megacolon) of the involved segment with or without pseudopolypoid changes and large penetrating ulcers.[6] This dilation should not be confused with dilation which can occur proximal to the partially obstructing involved segment.



Figure 6. Same patient as Figure 3. Superior mesenteric arteriogram demonstrating hypervascularity and "staining" in the splenic flexure.

The indication for angiography must be individualized based on multiple clinical factors. Frequently, ischemic colitis will show no *major* vascular occlusion although sometimes ischemic change is realted to occlusion of a major vessel from embolus, thrombosis, aortic surgery, etc.[3] Paradoxically, if angiography is performed during the healing phase increased vascularity with draining veins (simulating neoplasm) may be demonstrated secondary to the hyperemia (see Figure 6).[4] ★★★

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Did you hear about Harry? He mixed LSD with IBM and went on a business trip.

Hallucinogenic Mushrooms in Mississippi

KEITH W. JACOBS, M.A.
Hattiesburg, Mississippi

This paper reviews the availability of several hallucinogenic mushrooms in the state, with particular emphasis on Psilocybe cubensis. *The mushroom is discussed in terms of its natural habitat, seasonal availability, and active ingredients. The abuse of this mushroom is discussed in terms of method of preparation, course of effects, and abusers' preferences for this drug. The accidental and intentional use of toxic* Amanita *mushrooms is also noted.*

MISSISSIPPI and adjacent states are rapidly receiving a reputation in the drug culture as the "mushroom capital" of the United States. Since the 1950s, when a number of scientific articles[1] and articles in the popular press[2, 3] discussed the ritualistic use of hallucinogenic mushrooms in Mexico, the "magic mushrooms of Mexico" have been identified in the United States. Within the past four years several books have appeared in the underground press which extoll the virtues of these mushrooms, provide explicit field guides for obtaining them, and even provide recipes for their consumption.[4-6]

The traditional hallucinogenic mushroom has been *Psilocybe mexicana.* It was this mushroom which gained fame in the 1950s and is still the most frequently cited hallucinogenic mushroom. *Psilocybe mexicana* is the prototype of the *Psilocybe* genus, which contains over a dozen species, most of which have been found to contain psilocin and psilocybin as the active ingredients. The most prevalent *Psilocybe* mushroom in this part of the country is *Psilocybe cubensis,* also identified as *Stropharia cubensis.* In terms of psychotropic effects and active ingredients, *Psilocybe cubensis* does not appear to differ from *Psilocybe mexicana.*

It is surprising that *Psilocybe cubensis,* and a slightly more distant cousin *Panaeolus subbalteaus,* have not received extensive attention in the regional or national scientific literature. *Psilocybe cubensis* is distributed abundantly in Louisiana, Mississippi and Alabama, and has been reported to be naturally occurring in Florida and California.[6] This species is prevalent 24 hours after a spring or fall shower and is almost exclusively found growing on cattle manure in well drained pasture land. Amateur mycologists presume to have found *Psilocybe cubensis* based on the presence of all of the following criteria: its physical location, gills beneath the cap, hollow stem, and stem turns inky blue within an hour of being broken and exposed to the air.[6]

Panaeolus subbalteaus, the second native hallucinogenic mushroom, is frequently found growing amid clumps of *Psilocybe,* has the same hallucinogenic effects, and apparently has the same ingredients. It is, however, much less common than *Psilocybe cubensis* and is physically distinctive. This difference in physical appearance frequently causes it to be overlooked or discarded by the *Psilocybe* hunter. The knowledge that there is another mushroom besides *Psilocybe,* together with incomplete information about it, may contribute to accidental poisoning from the toxic varieties.

A great amount of ingenuity has gone into the development of recipes for eating these mushrooms. The more traditional approach is to prepare them as edible mushrooms, such as frying them in butter. Variations include eating them raw in the field, drying them so they can be eaten later, drying and grinding them in a blender so they can be placed in gelatin capsules, or freezing them in the ice box for later cooking. Neither drying or freezing appears to reduce the potency of the drugs.[7] An even newer approach is to boil the mushrooms in water to re-

Based on a paper presented at the Mississippi Academy of Sciences in 1974.

move the active ingredients (which are soluble in hot water), use the water to prepare foods such as rice or soups, and discard the remains of the mushrooms. This is the basic recipe for hallucinogenic beverage such as "magic cool aid." Reports from users indicate that the boiling method is preferred by those who have tried it, since it is relatively free from detection by law enforcement agents and eliminates the somewhat undesirable taste which may accompany raw or fried mushrooms.

Potency differences have been reported between fresh *Psilocybe* mushrooms in relationship to seasonal and growth effects.[6] Specimens are apparently less potent during the dry hot months and following periods of excessive rain. Naturally, the amount of psilocybin and psilocin consumed depends greatly upon the size of the mushroom, but from 2 to 6 average sized mushrooms appears to be the minimum effective dose.

OBSERVATIONS

During the past 2 years a number of regular mushroom users have been observed at various intervals of time following ingestion of *Psilocybe cubensis*. The extent of actual mushroom use in this area is apt to be underestimated by the observation of only a dozen users but it may be noted that these observaions have been the result of accidental discovery of these users while pursuing other research interests or social endeavors. As a matter of scientific curiosity, the observations were carried out as unobtrusively as possible and with a minimum of intervention. The observed effects of *Psilocybe cubensis,* and the effects reported by these users, will not be discussed in detail other than to note that they agree closely with the effects usually attributed to hallucinogenic drugs or the magic mushrooms of Mexico.[1] One advantage to *Psilocybe* mushrooms appears to be that unlike most hallucinogenic drugs purchased on the street, the adulterating impurities such as strychnine, quinine, and stimulants are absent. The only adverse effects reported from the mushrooms have been some loss of balance, some dizziness, and minimal nausea, all of which have been reported by these users to sometimes accompany or precede the onset of hallucinogenic effects. The onset of hallucinogenic effects has been reported from 5 minutes when consumed in liquid form to 30 minutes when eaten with other foods, but these times may be underestimates and may be influenced by the user's expectation of an effect. Peak hallucinogenic effects seem to occur and decline gradually with a median duration of effect of approximately 4 hours. Both duration and intensity of effect have been reported by the users to be dose related. No after-effects have been observed or reported by these users.

Aside from the psychologically disruptive effect of *Psilocybe,* which appears to be primarily perceptual, and the possibility of legal complications, one of the major problems is that a number of mushroom "mistakes" occur each year. These mistakes generally involve the ingestion of a toxic species which has either been mistakenly harvested or has been consumed intentionally. The most common mistake is to identify the toxic *Amanita muscarina* as a *Psilocybe.* Aside from obvious physical differences between these mushrooms, *Amanita* appears to require a longer growth period to reach full size and maximal concentration of its toxic ingredients. The advantage here is that if a *Psilocybe* hunter accidentally picks an *Amanita* the first day after a spring shower, it may not be full sized and may not contain a large amount of the toxic ingredient. Unfortunately, the *Amanita* species are likely to occur throughout the summer and to have high concentrations of muscarine when *Psilocybe* mushrooms are scarce. The ingestion of certain species of *Amanita,* even in moderate quantities, may well prove fatal if not treated.

Despite this fact, a new trend to actively seek *Amanita* species has been observed, apparently on the belief by some users that *Amanita muscarina* is the "sacred mushroom." The individuals who have intentionally consumed *Amanita* mushrooms have indicated unanimously that they found no hallucinogenic effects. These subjects also reported unanimously that they experienced excessive perspiration, and most subjects also reported blurred vision (apparently a failure in accommodation). Even though Schultes[8] reported that *Amanita* has been used for centuries in Siberia as an inebriant, such a practice locally can be very dangerous. The incidence of mushroom poisoning in the U. S. has not been very high but most of these cases have been due to *Amanita* species, particularly *A. phalloides, A. vera,* and *A. verna.*[9] The omission of *A. muscarina* from this list is probably due to its rapid production of gastrointestinal disturbance. Wide variability in the physical appearance of the *Amanita* species increases the likelihood of confusing the more toxic Amanitas with *Amanita muscarina.* The pharmacology and treatment of *Amanita* poisoning is well reported in the medical literature.

There is every reason to believe that the intentional use of *Psilocybe* and *Panaeolus* mushrooms will increase, and along with this increase will be an increase in the intentional and accidental consumption of *Amanita* species. All of these mushrooms are well publicized in the underground press and have a number of desirable qualities for both the regular and occasional drug users. Judging from the comments made by users of *Psilocybe* mushrooms, this is the "ideal" hallucinogenic agent, it is readily available, and is the cheapest hallucinogen available. Considering these factors, medical practitioners in a number of settings should be alerted to the problems which will probably become more frequently reported in the future, especially to the dangers of accidental poisoning from Amanita in users of other mushrooms. ★★★

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Gonorrhea

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UNCOMPLICATED GONOCOCCAL INFECTIONS IN MEN AND WOMEN

Drug Regimen of Choice

Aqueous procaine penicillin G (APPG), 4.8 million units intramuscularly, divided into at least two doses and injected at different sites at one visit, together with one gram of probenecid, by mouth, just before the injections.

Alternative Regimens

A. Patients in whom oral therapy is preferred: Ampicillin, 3.5 gm, by mouth, together with one gram probenecid by mouth, administered at the same time. There is evidence that this regimen may be slightly less effective than the recommended APPG regimen.
B. Patients who are allergic to the penicillins (penicillin G, ampicillin) or probenecid:*
   1. Tetracycline hydrochloride, 1.5 gm initially by mouth, followed by 0.5 gm by mouth four times per day for 4 days (total dosage, 9.5 gm). Other tetracyclines are not more effective than tetracycline hydrochloride. All tetracyclines are ineffective as single-dose therapy.
   2. Spectinomycin hydrochloride, 2.0 gm intramuscularly, in one injection.

Treatment of Sexual Partners

Men and women with known recent exposure to gonorrhea should receive the same treatment as individuals known to have gonorrhea. Male sex partners of persons with gonococcal infection must be examined and treated because of the high prevalence of nonsymptomatic urethral gonococcal infection in such men.

Followup

Followup urethral and other appropriate cultures should be obtained from men, and cervical, anal and other appropriate cultures should be obtained from women, 7 to 14 days after completion of treatment.

---

* Allergy to penicillin, ampicillin, probenecid, or previous anaphylactic reaction.

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Treatment Failures

Most recurrent infection after treatment with the recommended schedules is due to reinfection. True treatment failure after therapy with penicillin, ampicillin or tetracycline should be treated with 2.0 gm of spectinomycin intramuscularly.

Postgonococcal Urethritis

Tetracycline, 0.5 gm, four times daily by mouth, for at least 7 days.

Pharyngeal Infection

Pharyngeal gonococcal infections may be more difficult to treat than anogenital gonorrhea. Post-treatment cultures are essential followup for pharyngeal infection. The schedules of ampicillin and spectinomycin recommended for anogenital gonorrhea are ineffective in pharyngeal gonorrhea. Patients with pharyngeal gonorrhea whose infection is not eradicated after treatment with 4.8 million units of APPG plus one gram of probenecid, may be treated with 9.5 gm of tetracycline in the dosage schedule outlined above (Alternative Regimens).

Syphilis

All patients with gonorrhea should have a serologic test for syphilis at the time of diagnosis. Seronegative patients without clinical signs of syphilis, who are receiving the recommended parenteral penicillin schedule, need not have followup serologic tests for syphilis. Patients treated with ampicillin, spectinomycin, or tetracycline should have a followup serologic test for syphilis after 3 months to detect inadequately treated syphilis.

Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Not Recommended

Although long-acting forms of penicillin (such as benzathine penicillin G) are effective in syphilotherapy, they have *NO* place in the treatment of gonorrhea. Oral penicillin preparations such as penicillin V are not recommended for the treatment of gonococcal infection.

TREATMENT OF UNCOMPLICATED GONORRHEA IN PREGNANT PATIENTS

A. For women who are not allergic to penicillin: Use the regimens of aqueous procaine penicillin G plus probenecid, or use ampicillin plus probenecid, as defined above.
B. Pregnant patients who are allergic to penicillins (there are several possible alternative regimens, each of which has potential disadvantages):
    1. Erythromycin, 1.5 gm orally, followed by 0.5 gm four times a day for 4 days, for a total of 9.5 gm. This regimen is safe for mother and fetus, but efficacy has not been established. Erythromycin estolate should not be used in patients with underlying liver disease.
    2. Cefazolin, 2 gm intramuscularly, with 1.0 gm of probenecid. Because of the possibility of cross-allergenicity between penicillins and cephalosporins, this regimen should not be used in a patient with a history of penicillin anaphylaxis.
    3. Spectinomycin, 2 gm intramuscularly. This is an effective dose, but safety for the fetus has not been established.

Contraindicated

Tetracycline should not be used for uncomplicated gonococcal infection in pregnancy because of potential toxic effects for mother and fetus.

ACUTE SALPINGITIS (PELVIC INFLAMMATORY DISEASE)

The diagnosis of acute salpingitis should be considered in women with acute lower abdominal pain and adnexal tenderness on pelvic examination. Since there are no completely reliable clinical criteria on which to distinguish gonococcal from nongonococcal salpingitis, endocervical cultures for *Neisseria gonorrhoeae* are essential in such patients. Therapy, however, should be initiated immediately, without waiting for the results of the cultures.

A. *Hospitalization:* Hospitalization should be strongly considered for women with suspected salpingitis in these situations:
    1. Uncertain diagnosis, where surgical emergencies must be excluded.
    2. Suspicion of pelvic abscess.
    3. Pregnant patients with salpingitis.
    4. Inability of the patient to follow an outpatient regimen of oral medication, especially because of nausea and vomiting.
    5. Failure to respond to outpatient therapy.
B. *Antimicrobial Agents:* Controlled studies of the treatment of acute salpingitis are not available. Initial management must *AT LEAST* be adequate for gonococcal salpingitis. These regimens are known to be adequate for the treatment of gonococcal salpingitis:
    1. Outpatients:
        a. 1.5 gm tetracycline hydrochloride, given as a single oral loading dose, followed by 500 mg, taken orally, four times daily for 10 days.

b. Aqueous procaine penicillin G (APPG), 4.8 million units intramuscularly, divided into at least two doses and injected at different sites at one visit, *OR* 3.5 gm of oral ampicillin. One gram of oral probenecid is given along with either penicillin or ampicillin, and both are followed by 500 mg of ampicillin, taken orally, four times daily for 10 days.

2. Hospitalized patients:
   a. Aqueous crystalline penicillin G, 20 million units, given intravenously each day until clear-cut improvement occurs, followed by 500 mg of ampicillin taken orally four times daily, to complete 10 days of therapy. The need for additional or alternative antibiotics for the treatment of nongonococcal salpingitis requires further study. Since it is impossible to distinguish gonococcal from nongonococcal salpingitis clinically, many physicians also use an aminoglycoside in addition to penicillin and/or antibiotics which are effective against *Bacteroides fragilis* as initial therapy.
   b. Tetracycline hydrochloride, 500 mg, given intravenously four times daily until improvement occurs, followed by 500 mg taken orally four times daily, to complete 10 days of therapy. This regimen should not be used for pregnant women or for patients with renal failure.
3. Failure to improve on the recommended regimens does not necessarily indicate the need for stepwise additional antibiotics, but requires reassessment of the possibility of other diagnoses and of the specific microbial etiology.

C. The effect of the removal of an intrauterine device on the response of acute salpingitis to antimicrobial therapy and on the risk of recurrent salpingitis requires further study.

D. *Adequate treatment of women with acute gonococcal salpingitis must include examination and appropriate treatment of their male sex partners because of the high prevalence of nonsymptomatic urethral gonococcal infection in such men. Failure to treat male sex partners is a major cause of recurrent gonococcal salpingitis.*

E. Followup of patients with acute salpingitis is essential. All patients should receive repeat pelvic examinations and cultures for *N. gonorrhoeae* after treatment.

DISSEMINATED GONOCOCCAL INFECTION

A. Equally effective treatment schedules in the arthritis-dermatitis syndrome include:
   1. Aqueous crystalline penicillin G, 10 million units intravenously per day for 3 days, or until there is significant clinical improvement. This may be followed with ampicillin, 500 mg four times a day orally, to complete 7 days of antibiotic treatment.
   2. Ampicillin, 3.5 gm orally, plus probenecid, 1.0 gm, followed by ampicillin, 500 mg four times per day orally, for at least 7 days.

B. In penicillin and/or probenecid allergic patients:
   1. Tetracycline, 1.5 gm orally, followed by 500 mg four times a day orally, for at least 7 days. Tetracycline should not be used for complicated gonococcal infection in pregnancy because of potential toxic effects for mother and fetus.
   2. Erythromycin, 0.5 gm intravenously every 6 hours, for at least 3 days.

C. Additional measures:
   1. Hospitalization is indicated in patients who are unreliable, have uncertain diagnosis, or have purulent joint effusions or other complications.
   2. Immobilization of the affected joint(s) appears helpful. Repeated aspirations and saline irrigations appear beneficial, but controlled studies of these procedures have not been performed. Open drainage of joints other than the hip is now generally discouraged in patients with gonococcal arthritis.
   3. Intra-articular administration of penicillin is unnecessary, since penicillin levels in the synovial fluid of inflamed joints approximate serum levels; furthermore, intra-articular injection per se may produce a toxic synovitis.

D. Meningitis and endocarditis due to the gonococcus require high-dose intravenous penicillin therapy (at least 10 million units per day) for longer periods: usually at least 10 days for meningitis and 3 to 4 weeks for endocarditis.

GONOCOCCAL INFECTION IN PEDIATRIC PATIENTS

Pediatric patients encompass those from birth to adolescence. When a child is post-pubertal and/or

weighs over 100 pounds, he or she should be treated with dosage regimens as defined above for adults.

WITH GONOCOCCAL INFECTION IN CHILDREN, THE POSSIBILITY OF CHILD ABUSE MUST BE CONSIDERED!

The efficacy of therapeutic regimens for uncomplicated and complicated gonococcal infections of childhood is unproven at present.

Prevention of Neonatal Infection

All pregnant women should have endocervical cultures examined for gonococci as an integral part of prenatal care.

Prevention of Gonococcal Ophthalmia

A. One per cent silver nitrate (do not irrigate with saline, as this may reduce efficacy).
B. Ophthalmic ointments containing tetracycline, erthromycin, or neomycin are also probably effective.
C. NOT RECOMMENDED: Bacitracin ointment (not effective) and penicillin drops (sensitizing).

Management of Infants Born to Mothers With Gonococcal Infection

Orogastric and rectal cultures should be taken from all patients. Blood cultures should be taken if septicemia is suspected. Aqueous crystalline penicillin G, 50,000 units/kg/day, should be administered in two daily doses intravenously, if cultures or Gram-stained smears reveal gonococci. The duration of therapy should be determined by clinical response. In suspected septicemia, an aminoglycoside should also be administered.

Neonatal Disease

A. Gonococcal ophthalmia: Patient should be hospitalized. Antimicrobial agents: Aqueous crystalline penicillin G, 50,000 units/kg/day, in two or three doses intravenously for 7 days, PLUS frequent saline irrigations and instillation of penicillin, tetracycline or chloramphenicol eyedrops.
B. Complicated infection: Arthritis and septicemia should be treated by hospitalization and administration of aqueous crystalline penicillin G, 75,000-100,000 units/kg/day, in four doses, or procaine penicillin G, 75,000-100,000 units/kg/day, in two doses, for 7 days. Meningitis should be treated with aqueous crystalline penicillin G, 100,000 units/kg/day, divided into two or three daily intravenous doses and continued for at least 10 days.

Childhood Disease

Gonococcal ophthalmia should be treated with hospitalization and by the administration of aqueous crystalline penicillin G intravenously, 75,000-100,000 units/kg/day, in four doses, or procaine penicillin G, intramuscularly, 75,000-100,000 units/kg/day, in two doses, for 7 days, *PLUS* saline irrigations and instillation of penicillin, tetracycline or chloramphenicol eyedrops. Topical antibiotics *alone* are *NOT* recommended in therapy of gonococcal ophthalmitis. The source of the infection must be identified.

Uncomplicated vulvovaginitis and urcthritis usually do not require hospitalization. Both may be treated at one visit with aqueous procaine penicillin G, 75,000-100,000 units/kg intramuscularly, and probenecid, 25 mg/kg by mouth. Topical and systemic estrogen therapy are of no benefit in vulvovaginitis. All patients should have followup cultures, and the source of infection should be identified, examined and treated.

Infection complicated by peritonitis or arthritis should be treated by hospitalization and administration of aqueous crystalline penicillin G, intravenously, 75,000-100,000 units/kg/day, in four doses, or procaine penicillin G, 75,000-100,000 units/kg/day intramuscularly, in two doses for 7 days.

Treatment of patients with allergy to penicillin: Patients under 6 years of age should be treated with erythromycin, 40 mg/kg/day, in four doses by mouth, for 7 days, for uncomplicated disease. Complicated disease should be treated with cephalothin, 60-80 mg/kg/day in four doses intravenously, for 7 days. Patients older than 6 may be treated with an oral regimen of tetracycline, 25 mg/kg, as an initial dose, followed by 40-60 mg/kg/day in four doses, for 7 days, or an intravenous regimen consisting of tetracycline, 15-20 mg/kg/day, in four doses, for 7 days.

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Radiologic Seminar CXXXXVIII: Recurrent Gastric Bezoar in a Postgastrectomy Patient

ROBERT P. HENDERSON, M.D.
Jackson, Mississippi

IN THE POSTGASTRECTOMY patient, a slightly dilated gastric pouch containing a mottled bolus of food is strong evidence of a gastric bezoar. Serial abdominal radiographs showing no change in the pattern should arouse an even higher index of suspicion. An upper gastrointestinal series demonstrating barium surrounding and mixing with the matrix of a spherical mass is diagnostic of a bezoar.[1]

This case is that of a 58-year-old female who had subtotal gastric resection with vagotomy for a bleeding peptic ulcer. Symptoms of nausea and vomiting after meals with moderate epigastric pain first occurred six months after the gastric resection. The bezoar was removed at the time of gastroscopy by lavage. A year later she developed another bezoar which was again removed by aspiration and irrigation. Because of partial obstruction at the anastomosis site a revision of the gastrojejunostomy was carried out two months later. Four months later she again admitted to the hospital wih severe epigastric pain associated with nausea, vomiting and loss of appetite. On each of these occasions, there was a history of dietary indiscretion, although this information was not freely given by the patient. Orange pulp was found in the first bezoar and figs were the offending agent on the last occasion.

Unlike bezoars in the intact stomach which are usually trichobezoar (hair) or diospyrobezoar (persimmons), postoperative bezoars are phytobezoars (plant fiber). Orange pulp accounts for 90 per cent of the cases.[2] Grapefruit, figs, apples, celery, Brussels sprouts, potato peel, beans, berries, and cabbage have all been reported as the responsible material.

Effective dentition and proper eating habits are most important in the prevention of the bezoar.

Lavage was the basic treatment in this case. Other non-operative techniques that have been successful are liquid diet for two to three weeks, proteolytic enzymes such as Papase tablets (two tablets chewed four times daily) or Adolph's meat tenderizer (one teaspoonful with clear liquid one hour before meals and at bedtime), or a cellulace enzyme, Gastroenterace. Deal et al[3] described a case with dissolution of a bezoar using the method of Pollard and Block which consists of three Gastroenterace tablets



Figure 1. Note the slightly dilated gastric pouch containing mottled food material. This is particularly important when related to the symptomatology in a postgastrectomy patient.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Hospital, Jackson, Miss.



Figure 2. Barium surrounding and mixing with a prominent spherical or ovoid filling defect is characteristic of a gastric pouch bezoar.

with water after meals for three days. Each tablet contains 150 mg of pepsin, 100 mg of pancreatic enzyme, 25 mg of cellulace, and 50 mg of dehydrochloric acid.

Factors related to the bezoar formation in the postgastrectomy patient include: (1) Vagotomy resulting in an atonic gastric pouch and decreased or absent gastric acidity is commonly associated with bezoar formation, but cases have been reported in the postoperative ulcer without a vagotomy.[4] (2) Loss of normal mixing function of the distal stomach is important in the ingestion of high content cellulose foods. The churning action decreases the size of the fibers allowing passage from the intact stomach. (3) The size of the anastomosis may be of some importance although followup upper gastrointestinal series rarely shows a narrowing. The postgastrectomy patient is also likely to develop the same type of bezoar in the distal ileum, 50 to 75 cm proximal to the ileocecal valve.[2]

In conclusion, bezoars in the postgastrectomy patient may occur in the gastric pouch or ileum. Proper mastication of food and avoidance of high content cellulose foods, particularly oranges, should eliminate this postoperative complication. Transient symptoms related to fiber foods are probably common. The treatment of a bezoar in the gastric remnant is usually non-surgical. ★★★

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INFLATION

We know a teacher who's retiring after 50 years. When he started, he made $5 a week and all he could afford was a one-room apartment and onion sandwiches. But he worked and studied and got promotions and gave everything he had to his job. So now, after 50 years, he's retiring with a real nice pension—and all he can afford is a one-room apartment and onion sandwiches.



The President Speaking

"Human Satisfaction"

J. T. DAVIS, M.D.
Corinth, Mississippi

THE HOLIDAYS have come and gone but the memories of kindnesses, the joy of giving and the gratitude of many linger on. The spirit of Christmas often provokes the best in all of us. Would that it prevailed throughout the year.

Once again the "Great Obsession" of human satisfaction has appeared—not in the Midwest, the Northeast, or on the West Coast but in our own midst. A Jackson, Mississippi, physician was the beneficent "Santa Claus" on this occasion, when he enclosed the following note in the statement of account to each of his patients at Christmas time.

TO ALL MY PATIENTS

My fees are in the usual and customary range for ophthalmologists in this area.

However, these are not usual and customary times. Many of my patients are on pensions or limited fixed incomes from various sources. Other persons have special situations that are affecting them at this time.

I hope this thought will be helpful to you. If you plan to handle your statement in December, please feel free to make an adjustment if you are in one of these situations. Perhaps a *discount* of 25% will be useful—more or less as your case requires.

This will apply *only* to your December statement. This will be a private matter between us and no discussion with our office is needed; just return the statement with an adjustment notation.

Merry Christmas!

It is apparent that this doctor (name withheld at request of the physician) has joined the ranks of those who believe it is more blessed to give than receive—that compassion for those less fortunate who struggle for existence may be found in the hearts of those who seek it—and that the "Great Obsession" of human satisfaction in giving of oneself, as well as one's money, has many intangible rewards.

Thanks, Doctor, for your worthy contribution toward improving the image of our medical profession. Too, thanks for reading the President's Page in the November 1974 issue. ★★★

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EDITORIALS

Continuing Medical Education

In recent years there has been a growing trend toward recertification and relicensure by both Medical Specialty Boards and State Licensure Bureaus. The day of being "certified for life" is rapidly coming to an end, as the Boards require either re-examination or documented evidence of continuing education to maintain certification. Rather than formal written or oral examinations, medical education on a continuing basis seems a more reasonable and palatable approach. Thus, it becomes mandatory that regional community hospitals establish an accredited continuing medical education program.

The Council on Medical Education of the Mississippi State Medical Association has received approval of its continuing medical education plan from the AMA. This allows MSMA to accredit programs of continuing medical education in Mississippi. Physicians participating in an accredited medical education program receive credit hours that may be applied toward the American Medical Association's Physician Recognition Award and toward Medical Specialty Board recertification.

Medical staffs of hospitals or other medical institutions may apply to the Council on Medical Education of MSMA for information to aid in organizing an accredited CME program.

GEORGE H. MARTIN, M.D.
Associate Editor
Vicksburg, Miss.

Facts Support Revision of Medicaid Fees

An out-dated schedule of physician's fees which has resulted in Mississippi physicians being forced to shoulder an undue portion of the cost of Medicaid in the state will be one of the prime targets of the Mississippi State Medical Association's legislative program for 1975.

State legislation under which Medicaid operates has locked in Mississippi physicians with a 1970 schedule of fees while payments to other providers of health services have been increased substantially during the past four-year period.

With the cost of goods and services paid by U. S. physicians rising a whopping 32.5 per cent since 1970, the result has been to require our state's medical profession to go a long way toward financing the services they render under Medicaid from their own pockets.

Doctors maintain that, faced with sharply increased expenses under today's inflated economy, it costs them more to see the patient and process the Medicaid claim than they receive from Medicaid under a payment schedule based on 1970 fees.

"Physicians have assumed the unfair burden of financing Medicaid long enough," says Dr. J. T. Davis, MSMA President. "And while they have been patient, other providers of health services under the program have received realistic upward adjustments in payments to them." For example, while physician's fees have been frozen, nursing home payments have increased 53 per cent since 1970 and hospital per diem payments under Medicaid have gone up 37 per cent during the same period.

Additional figures which strongly support the association's call for adjustment in physicians' fees have been compiled by MSMA. "Physicians throughout the state should bring these facts to the attention of their local legislators now," Dr. Davis said. "With fees presently permissible under Medicaid running in some cases almost one-third of usual and customary fees charged by Mississippi physicians on a statewide average, the inequity is obvious." In support, Dr. Davis cited the following figures, with those shown in the first column below representing amounts of Medicaid Fees allowed today, and the third column showing the Average Medicare fees in 1973:

Statewide Customary	*Medicaid Fee*	*Average Medicare*
Initial office visit:		
$15	$ 8	$10
Routine or follow-up visit:		
$8	4	6.40
First day admission hospital visit:		
$25	12	20.35
Follow-up hospital visit:		
$10	4	5
Hospital emergency room visit:		
$15	6	11

MSMA hopes to remedy such inequities through support in the 1975 legislative session of an amendment to the Medicaid law which would change the basis upon which fees are paid to physicians from the F-300 Surgical Schedule (Blue Cross) to either the F-450 Schedule or to the 1969 California Relative Value Study, with the conversion factor to be determined by the Medicaid Commission. House Bills 356 and 453 and Senate Bill 2249 have been introduced for this purpose.

Physicians also should point out to their legislators that, since the Medicaid program is funded by 80 per cent federal dollars, the cost to the state of a fair adjustment in fees paid to physicians under the program would amount to only 20 per cent of the total. —Reprinted from "MPAC Reports," October 1974.

Emergency Medical Care Unit Opens at Capitol

The MSMA Emergency Medical Care Unit in the Capitol Building at Jackson opened Jan. 7, 1975, for the eleventh consecutive year of service during the 1975 Regular Session of the Legislature.

The association's public service project is again staffed by Mavis Barlow, R.N., of Florence. Physician's services are provided by volunteer Doctors of the Day.

Response by the MSMA membership to DOD assignment requests has been wonderful, according to Dr. C. D. Taylor, Jr., of Pass Christian, chairman of the Council on Legislation. He added that the month of February has already been filled and only a few days are left in March.

Legislative leaders have praised the service which costs the state nothing. Physicians contribute their services, and association funds are used to defray direct expenses. Some pharmaceutical firms donate supplies and drugs. The state furnishes the unit space, a telephone, utilities and janitorial services.

Mrs. Barlow said the unit's practice is brisk. Conditions seen in previous years ranged from the common cold to heart attacks.

LETTERS

SIRS: Diiodohydroxyquin (Diodoquin—Searle), approved by the U. S. Food and Drug Administration for treatment of intestinal amebiasis, has also been widely prescribed for "chronic nonspecific diarrhea" in young children.

Chronic nonspecific diarrhea is a relatively uncommon, self-limited pediatric problem. Examination and laboratory study have revealed no evidence of abnormal structure or function. Symptoms seem unrelated to diet, but often become worse during periods of physical or emotional stress.

Five cases of bilateral optic atrophy have been reported in young children given diiodohydroxyquin. Decreased visual acuity occurred after total daily doses between 1300 and 3600 mg. for a duration ranging from eight weeks to just over two years. Other adverse effects include severe furunculosis, thyroid enlargement, dermatitis, fever, headache, and anal irritation.

Diiodohydroxyquin can cause optic atrophy and irreversible visual loss in children. It should not be used to treat "chronic nonspecific diarrhea."

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

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Book Review

General Ophthalmology. Sixth Edition. By Daniel Vaughan, M.D., Taylor Asbury, M.D., and Robert Cook, M.D. 316 pages with illustrations. Los Altos: Lange Medical Publications, 1971. $8.00.

There are available for the medical student and general physician today many, many ophthalmology texts. Many will not survive their first edition; some have been well received. This seventh edition of the Vaughan & Asbury text, *General Ophthalmology* by the Lange Medical Publications Group is well known to many of us. Because it is in paperback form and in black and white it is by far the least expensive good, general text available. It covers admirably the whole difficult subject of ophthalmology with its ramifications in the basic sciences, general medicine, and surgery.

There are several new or rewritten chapters in the present text. These include an entirely new chapter on tears, a new chapter on retinal pathology, and a new chapter on vitreous problems. There is a good updating of chapter 14 dealing with neuro-ophthalmology. This particular chapter was written in consultation with Dr. William Hoyt, the author of the now accepted standard reference for neuro-ophthalmology.

There is added information in the back of the book which will be useful to many physicians. There is one appendix dealing with visual standards which will be helpful in evaluating patients for drivers' licenses, and various definitions of legal blindness for income tax purposes. There is a list of services and organizations which provide helpful information and literature for visually handicapped persons. There is a table of all the commonly used eye medications available.

There are several shortcomings in the text in not offering complete information or even reference to several currently popular and emerging subjects of importance. These would include present therapy of diabetic retinopathy, the use of soft contact lenses from a therapeutic as well as cosmetic point, the use of intraocular lenses, and the phacoemulsification method for cataract surgery.

All in all, the text is highly recommended for medical students and for the busy general physician who needs to have available at least some guide or reference for handling ophthalmic problems.

RICHARD L. BLOUNT, M.D.
Jackson, Miss.

Medico-legal Briefs

THE MALPRACTICE CRISIS AND THE INSURANCE CARRIER

Malpractice *is* an ugly word. A single malpractice claim can tie up a good deal of your time for years and cause damaging publicity. An allegation of malpractice strikes at the heart and soul of your professional oath. The charge that you have given less than the best you can provide to a patient is a shattering charge. You feel betrayed. You resent the plaintiff's attorney earning money by doing his best to prove you did poorly.

Malpractice is an ugly word to us too. The sharp increase in the number of malpractice claims and jury awards, plus inflation, has increased claims payments, sharply hiked legal defense costs and made this business a major money loser. The malpractice crisis is on the brink of becoming a disaster, for us, and for you.

The above average risk this line of liability insurance represents and the degree of expertise required to deal with it has kept most insurance companies from entering the market. Currently only about a dozen insurance companies provide medical malpractice insurance coverage. I am uncertain how long any of us can continue. The conditions under which we market and service this business have deteriorated so much that in 1975 some doctors in some states may be unable to purchase standard malpractice coverage at any price.

There probably isn't a higher incidence of malpractice today; it's just that more patients elect to sue today.

This has sharply increased your malpractice insurance premiums, almost destroyed the availability of the coverage and increased health care costs for consumers.

If the malpractice crisis cannot be solved, it may develop that the only source of financial protection

for you will be a government system. Whether a federal program or 50 state funds, government intervention almost certainly will increase government's attempts to tell you how to practice medicine. . . .

Identifying the problems has not been easy. We have heard suggestions that the malpractice crisis could be solved if doctors would do a better job of policing their own profession, weeding out the incompetents. This may be the biggest obstacle of all to solving the problem—the assumption that while all doctors are harassed by plaintiff attorneys, only the incompetent commit malpractice. The truth is that the most highly qualified doctor in this audience can lose a malpractice claim because malpractice is what the law says it is, not what you think it is. Any one of you here today can face a malpractice allegation. Not because you are incompetent, but because the practice of medicine is complex and getting more complex. Because mistakes can happen even under the most competent practitioner. Because new techniques and drugs save lives that would have been lost before, but at the same time bring new risks. Because patients believe that modern medicine can cure just about anything and therefore expect more from their doctors. Because consumerism has educated patients to understand that a lawsuit is simply another means of gaining redress of their grievances, whether real or based on imaginary harms. Because some doctors and patients have lost the close rapport that once both enjoyed. And, because changes by the courts in negligence law are steadily eroding many of your standard and traditional legal defenses. . . .

Malpractice cases are expensive to settle. The legal defense costs are unusually high because of the time involved in investigation, pre-trial work, attempts at settlement and the trial itself if the case goes to trial. . . .

So, we have been investigating less costly and quicker claim settlement practices. To us, binding arbitration offers the most promise for speeding up the disposition of claims, thereby reducing settlement and legal defense costs, and of overcoming jury decisions based on emotion instead of law and facts.

Medical arbitration generally works in one of two ways:

An agreement may be reached between the plaintiff and the defendant to arbitrate an existing claim. If a lawsuit has been filed, it can be removed from the court docket and placed into arbitration. The other and more popular method is initiated by the patient signing an agreement, as part of his admission to the hospital, to arbitrate any future dispute. The patient has the right to retract the agreement within 30 days of his dismissal from the hospital. Admission to the hospital is not refused if the patient declines to agree to arbitration, and arbitration is not used for emergency room admissions.

Arbitration plans call for the formation of an arbitration panel, ideally composed of a lawyer familiar with medical liability litigation, a doctor in the specialty of the defendant doctor and a lay person.

There is only so much that we or any insurance company can do to alleviate the malpractice crisis. What we can do will not be adequate even to maintain the availability of malpractice insurance from private companies, much less to stabilize insurance rates. If this financial protection is going to continue to be available, there are some things that you must do as individuals and there are things your associations must do.

First, you must accept the fact that malpractice claims do not happen to someone else. There but for the grace of God go you.

Patients lack an appreciation of the complexities and hazards of medical practice. They undervalue the risk and assume there has been negligence when the outcome of their treatment is less than they expected. Many doctors are reluctant to describe fully the possible ill effects of a treatment or surgery. The result is that many patients tend to blame their doctors if results are less than hoped for. There must be an increased rapport between the doctor and the patient. There must be increased and improved flow of information from you to your patients and an improved listening on your part to your patients' concerns or unexpressed worries. That a patient does not express concern to you or does not ask questions about the nature of the illness or the risk of treatment or the prognosis of his ailment does not mean that he does not have questions or worries. It does not mean he does not want information. Most patients, I suspect, would prefer that the doctor volunteer information rather than for the patient to have to ask the right question. In some cases the patient simply may not know the right question. It is your responsibility to ascertain from what the patient says and does not say and how he acts as to what he wants to know. In addition to being healers of the body, you must become communicators.

It takes time. It means frustration in trying to communicate a complicated medical procedure. But you do your patient no service if he leaves your office assuming a guarantee of successful treatment.

You do your patient no service by failing to inform him of the common and inherent risks of any operation or procedure.

You also must be willing to serve on medical peer review groups. Under peer review, one doctor or a panel of doctors examines a malpractice claim and provides an opinion to the insurance company as to whether the defendant doctor did or did not depart from the standard of care. Insurance companies have claims people with the expertise to identify many claims that are clearly defensible. They can also determine many situations where the doctor has in fact departed from the standard of care. However, there are many cases in the middle—the gray area—where claims people need expert help. Peer review panels speed up the loss settlement process in questionable cases. The longer cases remain open, the higher the cost of settling them and the greater effect that inflation has on the ultimate settlement figure.

We must consider what remedial legislation is necessary to prevent the complete collapse of legal defenses. You, the public and legislators must recognize that doctors cannot be expected to be infallible and there must be some protection under the law.

According to common law, a doctor is held responsible for following the accepted standard of medical practice in his own community. This is called the locality rule. If he adhered to this standard, the doctor could not be held liable.

Today plaintiff attorneys are bringing in paid medical witnesses from all parts of the country, in all specialties, to testify as to the standard of care the local physician should have followed. Their excuse is that local doctors won't testify against colleagues.

We agree an injured party should be able to obtain competent medical testimony on a legitimate case of negligence. However, this "conspiracy of silence" argument often used by plaintiff attorneys frequently translates into the fact that an attorney simply was not able to find a local doctor whose medical opinion agreed with the attorney's legal conclusion. In our estimation, a plaintiff with a legitimate claim has little trouble obtaining adequate local medical testimony. Remedial legislation is needed to restore and retain the locality rule.

The statute of limitations continues to be extended. In other kinds of negligence actions, the statute runs from the date the injury occurred. In medical malpractice, many states apply a discovery rule. This means the statute does not begin to run until the patient discovers the alleged injury, which may be years after the treatment. . . .

Another area of needed legislation deals with the confidentiality of peer review groups. Legislation is needed to grant these groups immunity from legal action brought by a colleague who the panel has determined was not following good accepted practice.

A growing legal and communications problem for doctors revolves around the doctrine of informed consent. It is a basic principle of our society that every man has the fundamental right to the physical security and integrity of his body. In the past the physician was protected from an allegation of malpractice if he could show the patient had consented to the specific treatment or operation and that the patient was competent in the eyes of the law to give such consent. In many states, court decisions have steadily expanded what the doctor must tell the patient in order to secure true informed consent. In some states the doctor must inform the patient of virtually every conceivable risk, no matter how remote. The theory is that the patient should be able to make an intelligent choice from the possible courses of treatment or refuse treatment altogether. . . .

Here is an opportunity for you to seize the initiative . . . organize yourselves in every state . . . determine what your local legal situation is . . . then set a course of action to correct the problems you're facing. . . .

Somehow, we have to get a grip on this problem. Alone, neither the medical profession nor the insurance industry can expect success, but together our coordinated efforts can be effective.

But wishful thinking won't solve our problems. What we do and do together will be the measure of our success. We must attack the malpractice crisis with the best of our combined talent and resources. The stakes are too high . . . for you as medical professionals . . . for us as insurers . . . and for the health care consumers . . . to do anything less.

Excerpts from a speech by Waverly G. Smith, President, St. Paul Fire and Marine Insurance Company, presented on Oct. 10, 1974, before the American Academy of Ophthalmology and Otolaryngology.

PERSONALS

New medical staff officers at University Hospital in Jackson are: JAMES ARENS, chief of staff, and W. LAMAR WEEMS, vice chief. ROBERT SLOAN and MARVIN JETER will serve with Drs. Weems and Arens on the Executive Committee.

PERSONALS / Continued

Blair Batson of Jackson and UMC has received the Distinguished Service Award from the National Easter Seal Foundation after serving six years on the foundation's board of directors.

A. V. Beacham of Magnolia was among the Mississippi delegation which attended the National Democratic Party's mini-convention in Kansas City.

Richard C. Boronow of Jackson and UMC was guest speaker at the Minnesota Obstetrical and Gynecological Society meeting in St. Paul.

Alvin E. Brent, Jr., F. E. Fyke, Jr., and J. M. Hudson of Jackson have been named Fellows of the American College of Physicians.

Carlos M. Chavez, William O. Barnett and William A. Neely of Jackson and UMC attended the Southern Surgical Association meeting in Boca Raton, Fla.

T. F. Clay of Tutwiler was honored with a surprise birthday party by the Tutwiler Woman's Club. Dr. Clay, who has practiced medicine in Tutwiler for 64 years, was born on Christmas Day in 1885.

Northeast Mississippi Medical Society has passed a memorial resolution in honor of the late Rome Grafton Dabbs of Shannon, who was the oldest member of the society.

Rodney Frothingham of Greenville was guest speaker before the North Mississippi Medical, Dental, Pharmaceutical and Nurses Society meeting. He spoke on facial neuropathology.

Ben B. Johnson of UMC and Jackson was recently elected governor of the Mayflower Society, an organization for descendants of those who sailed across the Atlantic in 1620. William Bradford was the 10th generation grandfather of Dr. Johnson.

Edley H. Jones of Vicksburg was honored by the Vicksburg Rotary Club for 51 years of active participation in the civic organization. He was presented a commemorative plaque and a handmade hickory cane.

Robert Love of Greenville spent a week in Haiti working at the missionary hospital sponsored there by the Medical Benevolence Foundation of the Presbyterian Church of the U. S.

J. L. Pettis of Tupelo discussed the use of the Argon Laser in treatment of eye diseases at the Fulton Rotary Club meeting in December.

Mario R. Pineda announces the removal of his office for the practice of psychiatry from Southwest Mississippi Regional Medical Center to State Pharmacy Building, 230 State Street, in McComb.

Thomas A. Randle announces the opening of an office for the practice of internal medicine, cardiology and pulmonary disease at 407 South 11th Street in Oxford.

Ronald L. Rennick has associated with W. F. Stringer of Poplarville for the practice of family medicine at the Stringer Clinic on West Pearl Street.

Antonio M. Rubio announces the opening of his office for the practice of psychiatry at 1407 22nd Avenue in Meridian.

K. B. Stowers of Natchez announces the association of B. G. Trosclair for the practice of family medicine at 140 Jefferson Davis Boulevard.

Ouida Jo Trahan and Anice Fay Peters have opened their offices in the Reese Building on Highway 8 East in Cleveland. Dr. Trahan is in family practice and Dr. Peters specializes in internal medicine.

John J. White of Jackson recently attended a Seminar at the San Francisco Eye, Ear, Nose and Throat Hospital for a course in Ophthalmological Microsurgery including Phacoemulsification and Intraocular lenses.

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

Feb. 10-14, 1975

Urology Intensive Course

University Medical Center, Jackson
Feb. 10-14, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
W. Lamar Weems, M.D., associate professor of surgery and chief of the Division of Urology, the University of Mississippi School of Medicine

The course will emphasize practical urology as it relates to the non-urologist. The latest concepts and practices in common urologic diseases will be presented.

Feb. 17-21, 1975

OTOLARYNGOLOGY INTENSIVE COURSE

University Medical Center, Jackson
Feb. 17-21, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
Godfrey E. Arnold, M.D., professor of surgery, director of the Division of Otolaryngology, and associate professor of physiology-biophysics, the University of Mississippi School of Medicine

This course will present a basic review of otolaryngology for the primary care physician, including office treatment, detection of complications, and overview of special services. This will include audiology, vestibular testing, speech and voice rehabilitation, allergies, and neurotology. Lectures, seminars, clinics, rounds, demonstrations, and surgical observations will be supplemented by assigned reading.

Feb. 24-28, 1975

PEDIATRICS INTENSIVE COURSE

University Medical Center, Jackson
Feb. 24-28, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
J. M. Montalvo, M.D., professor of pediatrics and assistant professor of biochemistry, the University of Mississippi School of Medicine

Registrants will participate in intake and ward rounds, refresh their skills in such areas as scalp vein techniques, use of the respirator, nebulizer and humidifier, and attend lectures on such subjects as fluids, hematology, cardiology, immunizations, allergies, seizures, pediatric emergencies, pediatric surgery, renal problems, and the care of the newborn. Round table discussions will include pediatric problems.

All intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, pharmaceutical firms, volunteer health agencies, and private donation. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged for each.

FUTURE CALENDAR

Mar. 3-7, 1975
HEMATOLOGY-ONCOLOGY INTENSIVE COURSE

Mar. 12-14
CARE OF THE NEWBORN

Mar. 13-15
SURGERY FORUM

Mar. 20-22
NEUROLOGY-NEUROSURGERY INTENSIVE COURSE

Mar. 24-28
CARDIOLOGY INTENSIVE COURSE

Mar. 28
RENAL SEMINAR

Mar. 31-April 1
NEONATAL WORKSHOP

April 7-11
PULMONARY MEDICINE INTENSIVE COURSE

April 9-11
VENTILATOR I

April 14-18
NEPHROLOGY INTENSIVE COURSE

April 21-25
RADIOLOGY INTENSIVE COURSE

May 5-8
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

May 7-9
CARE OF THE NEWBORN

May 19-23
FAMILY PRACTICE REVIEW

May 21-23
VENTILATOR II

Fall 1975
DIABETES SEMINAR

NEW MEMBERS

CARTER, KENNETH GILBERT, Jackson. Born Baton Rouge, La., April 1, 1942; M.D., Louisiana State University School of Medicine, New Orleans, La., 1967; interned University of Oregon Medical School Hospital, Portland, Ore., one year; radiology residency, Thomas Jefferson University Hospital, Philadelphia, Pa., 1968-72; elected by Central Medical Society.

CHRISTIAN, RONNIE SCOTT, Jackson. Born Booneville, Miss., Sept. 10, 1947; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1972; interned Memorial Medical Center, Savannah, Ga., one year; elected by Central Medical Society.

DEARMAN, HENRY BURKETT, Etta. Born Wingate, Miss., May 14, 1921; M.D., University of Tennessee School of Medicine, 1946; interned Methodist Hospital, Memphis, Tenn., one year; psychiatry residency, University of Virginia, Charlottesville, Va., 1959-62; elected by North Mississippi Medical Society.

DEMENT, FRANK E., III, Hattiesburg. Born Meridian, Miss., Nov. 29, 1940; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1965; interned, same, one year; pediatric residency, same, Jan. 1969-Dec. 1970; elected by South Mississippi Medical Society.

FROTHINGHAM, RODNEY E., Greenville. Born Rolling Fork, Miss., July 25, 1937; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1965; interned Duke University Medical Center, Durham, N. C., one year; surgery residency, University Medical Center, Jackson, Miss., 1966-71; elected by Delta Medical Society.

GREGORY, RAY N., Corinth. Born Myrtle, Miss., Jan. 2, 1939; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1967; interned Baptist Memorial Hospital, Memphis, Tenn., one year; surgery residency, same, 1968-72; elected by Northeast Mississippi Medical Society.

HOFMANN, LARRY V., Vicksburg. Born Philadelphia, Pa., Aug. 22, 1942; M.D., Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pa., 1968; interned Jefferson Hospital, Philadelphia, Pa., one year; pediatric residency, Vanderbilt University Hospital, Nashville, Tenn., July 1971-June 1972; pediatric residency, University of Pittsburgh Children's Hospital, Pittsburgh, Pa., July 1972-July 1973; elected by West Mississippi Medical Society.

HUNTER, JOHN WILLIS, JR., Raleigh. Born Meridian, Miss., July 29, 1912; M.D., Washington University School of Medicine, St. Louis, Mo., 1938; interned Hillman Hospital, Birmingham, Ala., one year; surgery residency, Jefferson Hospital, Birmingham, Ala., Jan. 1946-July 1948; elected by Central Medical Society.

MCFATTER, CHARLES WAYNE, Vicksburg. Born Port Arthur, Tex., July 20, 1943; M.D., Baylor College of Medicine, Houston, Tex., 1968; interned University Hospital, Little Rock, Ark., one year; ob-gyn residency, same, 1969-72; elected by West Mississippi Medical Society.

RANDLE, THOMAS A., JR., Oxford. Born Memphis, Tenn., Oct. 14, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1967; interned Floyd Hospital, Rome, Ga., one year; internal medicine residency, Ochsner Foundation Hospital, New Orleans, La., 1970-73; elected by North Mississippi Medical Society.

Sports Medicine College Plans Meet

The American College of Sports Medicine has announced the tentative program for its Twenty-Second Annual Meeting to be held May 22-24, 1975, at the Marriott Hotel in New Orleans.

A wide range of sports medicine topics will be covered in informal sessions and symposia. These topics will include: Athletic Equipment Design and Injury Prevention; Guidelines for Exercise Stress Testing; The Montreal Olympics—Sex Determination and Drug Testing; Women in Sport—Physiological and Medical Aspects of Participation; Cellular Aspects of the Cardiac Muscle; The Child in Sport; The Merits of Taping—Debate and New Approaches; Ageing and Physical Activity; Scientific Writing; and Muscle Proprioception.

A delegation of Soviet scientists have accepted an invitation to present a symposium on the History and Current Status of Sports Medicine in the Soviet Union.

Dr. Jean Mayer, nutritionist from Harvard University, will be a featured speaker on the topic of Exercise and Nutrition.

For additional information contact the American College of Sports Medicine, 1440 Monroe Street, Madison, Wis. 53706.

The Mississippi PSRO Program Begins Operation in Three Hospitals

Members and staff of the Mississippi Foundation for Medical Care will begin phasing in and testing the Mississippi PSRO Program beginning this month. The North Mississippi Medical Center, Tupelo; King's Daughters Hospital, Brookhaven; and Bolivar County Hospital, Cleveland, will be the first Mississippi hospitals on the program. Hospitals will be brought on the program monthly on a schedule that will be completed by March 1976.

As noted in a brochure about the Mississippi PSRO Program mailed to all physicians and hospitals in the state . . . "The primary emphasis of the Mississippi PSRO Program will be at the local hospital level where the actual delivery of health care services occurs. The implementation in each hospital of a review system under the framework and guidelines of the PSRO will be the result of the cooperative efforts of the hospital staff, administration, and the PSRO . . ."

The review organization within a hospital will consist of review coordinators, review physicians selected by the hospital medical staff, and a professional review committee which may be either the hospital's present utilization review committee, medical audit committee, or a new committee. Working under the direction of the review physician, the review coordinators will conduct admission certification, length of stay monitoring, and quality of care assessment in accordance with norms, criteria, and standards developed by Mississippi physicians through their hospital medical staffs and specialty societies.

The PSRO is only required to provide its review system to beneficiaries of the Medicare, Medicaid, and Maternal and Child Health Care programs, but plans are being made to offer the review system, at cost, for all hospital admissions based on requests from hospitals and insurance carriers. When the PSRO becomes operational in a hospital it replaces all review activities presently being conducted by fiscal intermediaries.

The Mississippi PSRO now has over 1000 physician members. In October 1974, the PSRO membership participated in a mail ballot election of an interim Board of Directors to serve until the annual meeting of the membership to be conducted May 8, 1975, in Biloxi. Members of the Board are: James O. Gilmore, M.D., Chairman, Oxford; Robert S. Caldwell, M.D., Tupelo; Robert F. Carter, Jr., M.D.,



MFMC's PSRO staff is shown reviewing plans of the MFMC Board of Directors for implementation of the PSRO program in Mississippi. Seated from left are: Judy Michael, program planner and coordinator, and Barbara Moore, training and education coordinator. Standing from left are: Oren Rennick, director, professional division; Charles L. Mathews, executive director; Tom Buntyn, director, information division; and Rod LaGrone, director, administrative division.

Biloxi; Millard S. Costilow, M.D., North Carrollton; Joe S. Covington, M.D., Meridian; Everett Crawford, M.D., Tylertown; J. P. Culpepper, III, M.D., Hattiesburg; J. T. Davis, M.D., Corinth; Arthur A. Derrick, Jr., M.D., Durant; Gerald P. Gable, M.D., Hattiesburg; Lyne S. Gamble, M.D., Greenville; Sidney O. Graves, Jr., M.D., Natchez; Whitman B. Johnson, Jr., M.D., Clarksdale; Tom H. Mitchell, M.D., Vicksburg; Kenneth P. Pittman, M.D., Jackson; William H. Preston, Jr., M.D, Booneville; James W. Rayner, M.D., Oxford; James L. Royals, M.D., Jackson; C. D. Taylor, Jr., M.D., Pass Christian; and James T. Thompson, M.D., Moss Point.

An executive committee of the Board meets twice a month to review and supervise policy direction of the Mississippi PSRO. Members of the executive committee are: Tom H. Mitchell, M.D., Chairman, Vicksburg; J. T. Davis, M.D., Corinth; C. D. Taylor, Jr., M.D, Pass Christian; James W. Rayner, M.D., Oxford; William H. Preston, M.D., Booneville; Kenneth P. Pittman, M.D., Jackson; Robert F. Carter, M.D., Biloxi; Joe S. Covington, M.D., Meridian; Gerald P. Gable, M.D., Hattiesburg; and James T. Thompson, M.D., Moss Point.

DEATHS

DeLaureal, Boni James (Ret.), Pass Christian. Born Brussel, La., Sept. 25, 1903; M.D., Tulane University School of Medicine, New Orleans, La., 1927; interned Charity Hospital, New Orleans, La., one year; internal medicine residency, same, 1927-29; died Nov. 29, 1974, age 71.

Felts, Nollie Carpenter, Sr., Hattiesburg. Born Hattiesburg, Miss., Feb. 7, 1905; M.D., Tulane University School of Medicine, New Orleans, La., 1935; interned Touro Infirmary, New Orleans, La., one year; died Nov. 1, 1974, age 69.

Goodloe, William Henry, Jr., Jackson. Born Siloam Springs, Ark., Jan. 31, 1936; M.D., Tulane University School of Medicine, New Orleans, La., 1962; interned Confederate Memorial Medical Center, Shreveport, La., one year; ob-gyn residency, City of Memphis Hospitals, Memphis, Tenn., 1966-69; died Dec. 21, 1974, age 38.

Hunter, A. C., Columbus. Born 1896; M.D., Meharry Medical College School of Medicine, Nashville, Tenn., 1927; died Nov. 28, 1974, age 78.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension
Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

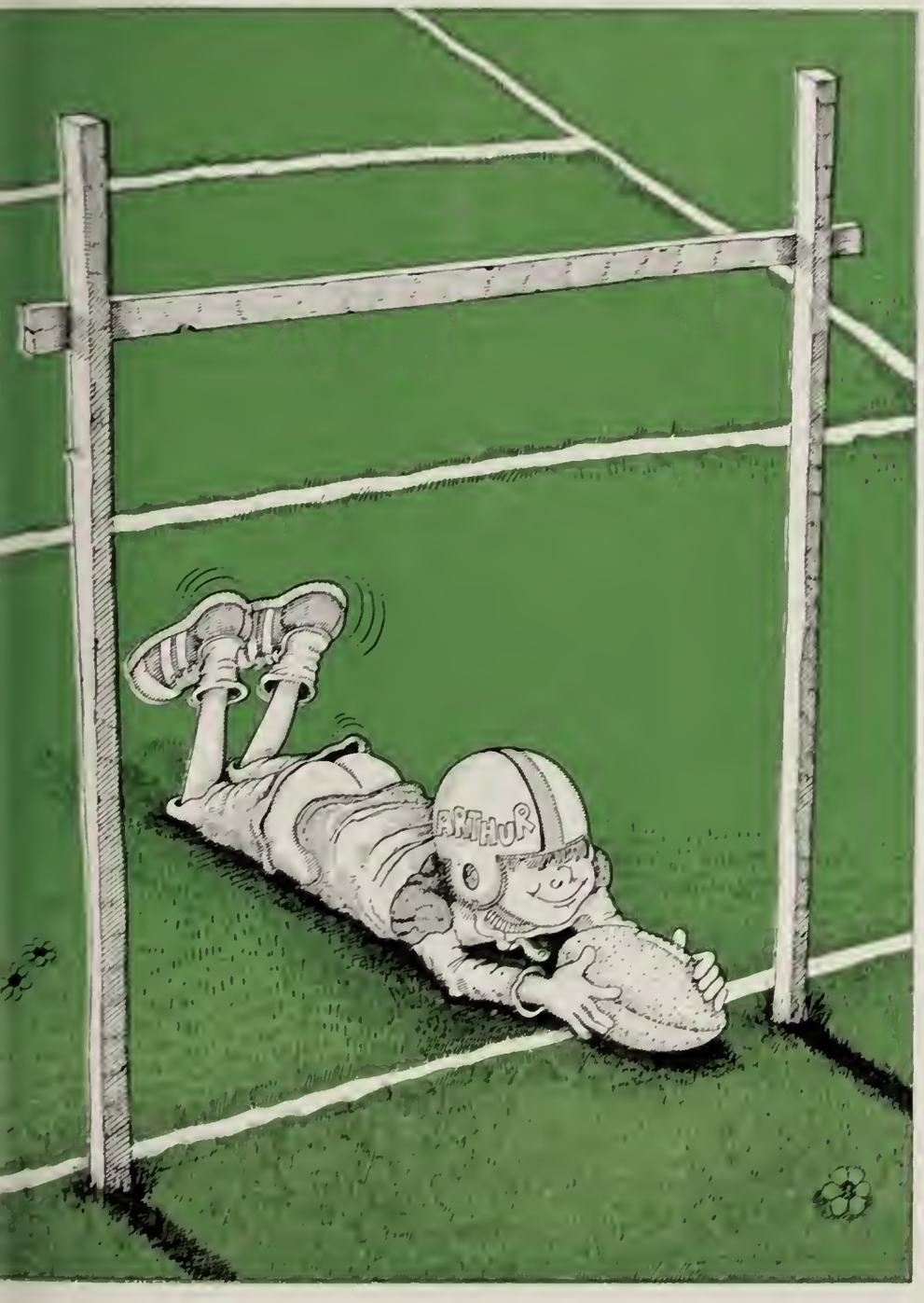
Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

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WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

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Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

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Please see prescribing information on facing page.

UMC Adds to Faculty

Ms. Freda Clarrette Bush and Dr. Dora S. Washington have been appointed to the faculty of the University of Mississippi School of Medicine at the Medical Center.

Ms. Bush is assistant professor of obstetrics and gynecology and associate director of nurse-midwifery programs, and Dr. Washington is an instructor in surgery (otolaryngology).

Vice Chancellor Dr. Norman C. Nelson announced the appointments, which became effective Jan. 1, 1975, following action of the Board of Trustees, Institutions of Higher Learning.

Dr. Washington, an instructor at Jackson State University since 1957, joined the University Medical Center staff as a speech pathologist in December. Her faculty appointment is the first in a special faculty exchange program with Jackson State. While Dr. Washington is on the Medical Center faculty, UMC instructor in surgery (otolaryngology) Ms. Linda Lowe will spend nine months at Jackson State.

Dr. Washington got her Ph.D. degree at Indiana University, Bloomington, Ind. Ms. Bush, who is also assistant professor of nursing, has an M.S. degree from Columbia University.

SBH Names TB Study Committee

A committee to review Mississippi's tuberculosis treatment program has been organized by the State Board of Health according to Dr. Alton B. Cobb, State Health Officer.

According to Dr. Cobb, the objective of the committee is to review the Mississippi tuberculosis treatment program and make recommendations regarding the future treatment of tuberculosis in the state. The committee is composed of members from the Mississippi Thoracic Society and the Mississippi Lung Association.

The committee members are Dr. John R. Williams, Greenville; Dr. Fred Tatum, Hattiesburg; Dr. John F. Busey, Jackson; Dr. Joe Norman, Jackson; Dr. Guy Campbell, Jackson; Mrs. Mary Jane Green, Grenada; Mr. Sneed McInvale, Laurel; and Mrs. Cecil Fox, Canton.

According to Dr. Cobb, the four objectives of the committee will be to review the size and distribution of the tuberculosis problem in Mississippi, to review the present tuberculosis treatment (inpatient and outpatient) program in the state, to review the current trends and recommendations for the hospital care and outpatient treatment of patients and to develop recommendations regarding the future treatment of tuberculosis in Mississippi.

According to Dr. Cobb, new active cases and case rates are declining in Mississippi and the United States, but tuberculosis remains a significant public health problem.

The number of reported new active cases has declined in Mississippi from 661 to 445 in 1973. The case rate has declined from 28.4 in 1965 to 19.5 per 100,000 in 1973.

Canadian Physician Visits Medical Center



Dr. John Bailey, riglit, of The Hospital for Sick Children in Toronto, Ontario, Canada, and visiting pediatrician at the University of Mississippi Medical Center, talks with Dr. David G. Watson, associate professor of pediatrics at UMC. While at the Medical Center, Dr. Bailey met with UMC faculty and students and spoke on "The Management of Delayed Adolescence" at the regular Center Assembly. He heads the Division of Pediatric Endocrinology and is director of the Research Institute at The Hospital for Sick Children.

Dr. Galbraith Is Rush Hospital Guest Speaker



Dr. J. Garber Galbraith (right), noted neurosurgeon from Birmingham, was guest speaker at a recent dinner meeting at Rush Foundation Hospital in Meridian. A number of physicians from throughout the area attended the meeting, including Dr. Stanley Wade of the Rush Medical Group (left) and Dr. Rolando Abangan, a Meridian neurosurgeon. Dr. Galbraith discussed "Surgical Aspects of Pituitary Disorders." Scheduled periodically at Rush, the dinner meetings give physicians in the Meridian area the opportunity to hear lectures by well-known specialists in the medical field.

SBH Home Health Program Provides Care

Many Mississippians need and receive special home nursing services through the State Board of Health's Home Health program.

Figures show that at the end of 1973-74 fiscal year, public health nurses in Mississippi made more than 53,000 skilled nursing visits to homebound patients on Medicare. The figure would almost reach 60,000 if coupled with Medicaid and Chronic Illness patients who also received service.

According to Dr. Alton B. Cobb, State Health Officer, the home health program began in 1965 after the Social Security Amendment, which included care for the elderly, became effective.

"Figures show that at the outset of the program there were approximately 279 public health nurses in Mississippi," Dr. Cobb said. "That first year there were less than 5,000 home health visits to patients eligible for medicare."

"At the end of FY 1973-74, there were 350 public health nurses in the state and they had made more than 53,000 skilled nursing visits to homebound patients on medicare."

Mrs. Zona Jelks, chief of the Bureau of Public Health Nursing, notes that the total number of visits would be near the 60,000 mark if the number of visits provided medicaid and chronic illness program patients were added to the medicare totals.

"We provide quality skilled nursing services regardless of the program that the patient is on," she said.

Mrs. Jelks cites two primary reasons for the success of the home health program sponsored by the Board of Health.

"Our program has been well accepted both by the medical community and the patients that they refer to the county health departments for home health services," she said. "We should probably also point out that almost 10 per cent of Mississippi's total population is over 65 years of age. This has also been a significant factor in the fast growth of our program."

Mrs. Jelks notes that almost 29 per cent of total nursing time goes into the disease and disability program, of which home health services is a prominent part.

"Of course, the agency is certified as a provider of services and meets both Social Security and Health, Education and Welfare standards," she added. "And, of course, each county health department is certified."

The State Board of Health received approximately $1.2 million dollars last year from medicare and medicaid for reimbursement for services provided.

That money is budgeted back into the county health departments to enable the health department to provide continuing home health services.

"We're not in the business for the money, even though it certainly helps in building a strong public health nursing program," she added. "We're in the business of service."

Governor Waller Appoints Two Physicians

Governor Bill Waller has announced the appointment of Drs. J. T. Davis of Corinth and James B. Martin of Monticello to the State Health Planning Advisory Council. The council serves in an advisory capacity to the Governor's Office of Comprehensive Health Planning.

A graduate of Vanderbilt University and the Medical School, Dr. Davis is presently serving as president of the Mississippi State Medical Association. He is a member of the First Baptist Church, Chamber of Commerce, Advisory Commission to the Appalachian Regional Health Program, the Mississippi Trauma Committee of the American College of Surgeons, and the Mississippi State Chamber of Commerce. He is Chairman of the Board of Directors for the Mississippi Foundation for Medical Care, a Certified Fellow in the American College of Surgeons and the International College of Surgeons, and a member of the Northeast Mississippi Medical Society and the American Medical Association.

A graduate of Millsaps College and the University Medical School, Dr. Martin is a general practitioner in Monticello. He is a member of the Mississippi State Medical Association, the American Medical Association, and the American Academy of Family Physicians.

The State Health Planning Advisory Council is charged with the responsibility for identifying health care needs and problems in Mississippi and for studying methods of implementing recommended improvements. The Advisory Council is also responsible for the review of capital expenditures by health facilities receiving federal money under the Social Security Act.

Report Cites Medicare Gaps

With the 94th Congress ready to consider national health insurance, the Senate Special Committee on Aging has issued a report citing limitations in the Medicare Program and the ability of private health insurance to fill the gaps.

According to the report, the typical private health insurance policy purchased by the elderly fills only the coinsurance and deductible gaps. The report was prepared by Dr. Gladys Ellenbogen, consultant economist, based on interviews with insurance commissioners from five states.

She estimates that more than half of the nation's Medicare beneficiaries—about 11.2 million—buy



Governor Waller is shown presenting certificates of appointment to Drs. J. T. Davis (at left) and James B. Martin. The two physicians are now members of the State Health Planning Advisory Council.

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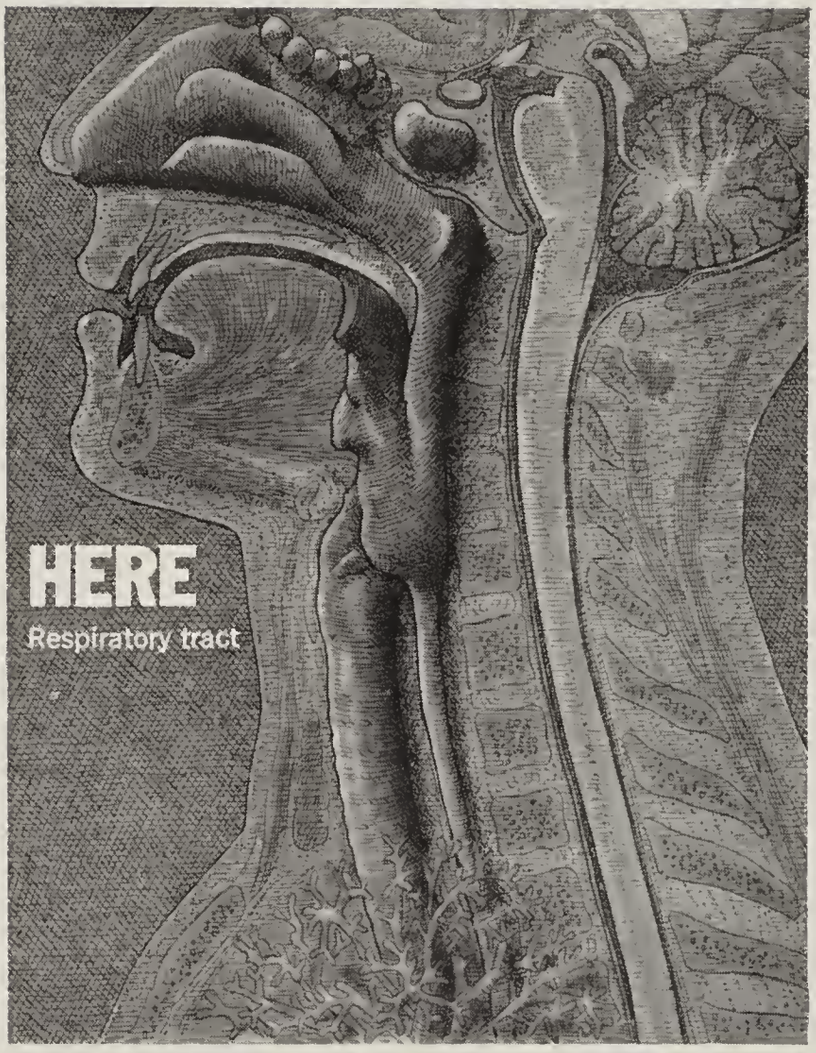
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Empirin Compound with Codeine **No. 3,** codeine phosphate* 32.4 mg. (gr. ½); **No. 4,** codeine phosphate* 64.8 mg. (gr. 1) *Warning—may be habit-forming. Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.



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#3, codeine phosphate* (32.4 mg.) gr. ½
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Magnolia Speech School Expands

Rev. Charles Gammel, director of Magnolia Speech School for the Deaf in Jackson, has announced that enrollment for the spring semester is to be open January 1 through March 1. This extended enrollment period is due to the increased capacity of the school in its new building on Flay Chapel Road.

Magnolia Speech School for the Deaf is a nonprofit organization dedicated to the teaching of hearing-impaired and language-impaired children. It serves the children of Mississippi and surrounding states as the only oral school for the deaf in this area. In addition to hearing-impaired children the school also accepts hearing children who are not learning speech and language in the normal manner.

At this time, the speech and language evaluations performed by the school are offered free of charge so that as many children as possible may be discovered.

Interested persons should contact Rev. Gammel at Magnolia Speech School for the Deaf (352-4168), P. O. Box 10373, Jackson, Miss. 39209, for further information.

Newborn, Ventilator Technique Courses Set

Mississippi physicians can take refresher training in newborn care and learn latest ventilator techniques in a special series of courses at the University Medical Center.

Newborn care courses March 12-14 and May 7-9 will focus on normal adaptation, identification of abnormal condition, and management of the sick neonate. Individualized instruction will cover metabolic problems, jaundice, seizures, surgical emergencies, nutrition, and other areas.

The first ventilator course, scheduled April 9-11, will deal with basic reasons for using and ways to use ventilator therapy with the newborn.

Ventilator II is an advanced course on the neonate with respiratory problems and how to use the ventilator in treatment. To be offered May 21-23, this course will be open only to individuals who have completed Ventilator I.

The University of Mississippi Medical Center Division of Continuing Health Professional Education and Division of Newborn Medicine sponsor the courses with partial support from the Mississippi Regional Medical Program and the Public Health Service, Department of Health, Education and Welfare.

Advance registration with $15 fee for each course should be addressed to Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson 39216.

SBH Offers Presentation on Smoking and Health

The Mississippi State Board of Health is now offering a presentation on smoking and health to demonstrate the harmful effects of cigarette smoking for schools, civic groups and voluntary organizations, according to Dr. Alton B. Cobb, State Health Officer.

"There is unequivocal evidence that cigarette smoking represents the major cause of excess morbidity and mortality for our citizens," Dr. Cobb said. "Educating the public to this fact is a continuing, difficult undertaking to which the State Board of Health is dedicated."

B. G. Garrison of the Bureau of Family Health Services has been designated as a smoking educator for the State Board of Health, according to Dr. Cobb.

"My presentation includes the use of a smoking mannequin to show the effects of smoking on the lungs to younger people and actual lung tissue of a smoker," Garrison said.

"The mannequin used in the demonstration is the equivalent size of a 12-year-old boy," said Garrison. "The lungs are represented by fruit jars filled with angel hair which shows the residue that collects in the lungs when a cigarette is smoked."

"I also carry pamphlets and posters of all types and a list of films available from our film library on smoking and health," he said.

The American Cancer Society, the Mississippi Lung Association, the Mississippi Heart Association and the Mississippi Cooperative Extension Service also offer similar programs, according to Garrison.

Any school, civic group of other organization desiring a program on smoking and health should contact B. G. Garrison, Bureau of Family Health Services, Mississippi State Board of Health, P. O. Box 1700, Jackson 39205, or call 601-354-6680 in Jackson.

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

MARCH 1975

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. Metastatic Choriocarcinoma, Health Care Delivery Crisis, Mammography

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ORIGINAL PAPERS

The Curability of Metastatic Choriocarcinoma

C. DOUGLAS ODOM, M.D., and RICHARD C. BORONOW, M.D.
Jackson, Mississippi

The most impressive cancer chemotherapy success story is the curability of the rare but highly malignant gestational choriocarcinoma. Because favorable results can be obtained, the physician should keep these rare tumors in mind, say the authors. Each patient must be carefully evaluated and given individualized treatment. They present an illustrative case report.

THE MOST IMPRESSIVE cancer chemotherapy success story is the curability of the rare but highly malignant gestational choriocarcinoma. With localized disease, cure is now expected uniformly. Even with metastatic disease at least 75 per cent of patients can be cured. While choriocarcinoma is usually preceded by hydatidiform mole, this neoplasm may develop as a sequelae of other gestational events, as normal pregnancy, in this case, and also from spontaneous abortion and ectopic pregnancy. Choriocarcinoma, occurring only once in every 150,000-200,000 pregnancies, is preceded by normal intrauterine pregnancy in 25 per cent of instances. When, as in the case presented, the gestational event is entirely normal, the onset of signs and symptoms is subtle and diagnosis is often delayed. This patient, with massive (by human chorionic gonadotropin quantitation) and widely disseminated disease (lung, liver and cerebral metastases), nevertheless is apparently cured of her malignancy.

CASE REPORT

Mrs. S. G., a 23-year-old Caucasian female gravida 2, para 2, was referred to the University Hospital with a four-week history of headache, weakness, nausea, vomiting, anorexia and 15-pound weight loss. Her first pregnancy ended on Aug. 18, 1970; her second pregnancy was terminated May 29, 1972. In both instances, prenatal course, labor and delivery were entirely normal. She was clinically well at her six-week postpartal checkup and was placed on oral contraceptives in July 1972.

She had apparently normal menses in August, September and October. In early November, attributing the headaches and vomiting to the birth control pills, she stopped them. This produced vaginal bleeding that she considered a normal "period." The nausea, vomiting and headaches worsened and she was admitted to her community hospital on Nov. 19, 1972. Studies included a chest x-ray which revealed a 1.5 cm. coin lesion in the right lower lung field. She was referred for further medical evaluation. After confirmation of the coin lesion, now 2 cm., in the right lower chest, the finding of a positive pregnancy test suggested the likelihood of metastatic gestational trophoblastic disease.

Physical Examination. Her blood pressure was 130/90, temperature 98.6 (F), pulse 100, and

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weight 117 pounds. The patient was a well developed, thin white female who appeared chronically ill but in no acute distress. Funduscopic exam revealed moderate papilledema. There was hepatomegaly seven to eight centimeters below the right costal margin in the nipple line. Pelvic exam was compatible with an early pregnancy; the uterus was soft, posterior, and approximately six weeks' size. No adnexal masses were palpable.

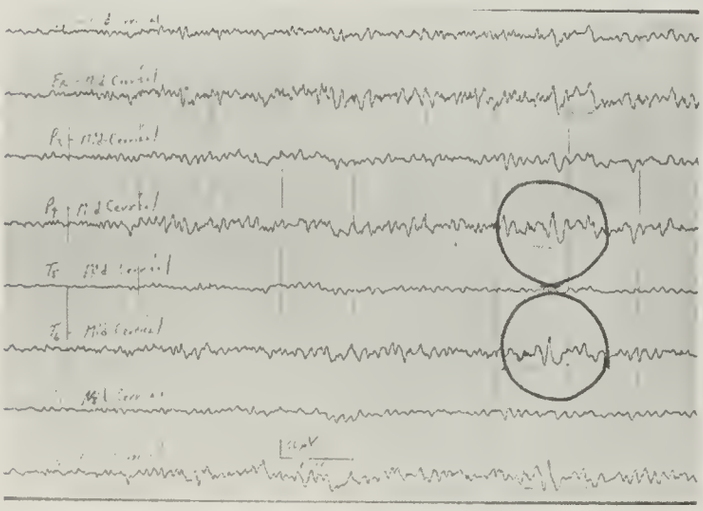


Figure 1. Electroencephalogram: Referential montage to midcervical electrode reference demonstrating irregular delta slow component, with intermixed sharp waves. The irregular delta slow component, commonly seen with neoplasms and avascular lesions is here more marked in the frontal and posterior temporal leads, indicating a posterior fossa space-occupying lesion.

Laboratory and X-ray Data. Laboratory findings were HGB 10.3, HCT 33, WBC 8,300, SGOT 60, LDH 564, alkaline phosphatase 135. Electroencephalogram (see Figure 1) and brain scan (see Figure 2) were compatible with a posterior fossa lesion. Vertebral arteriogram (see Figure 3, a and b) confirmed a structural lesion in the posterior fossa. Chest x-ray (see Figure 4, a and b) revealed a solitary coin lesion. Liver scan (see Figure 5, a and b) demonstrated focal lesions, possibly metastatic. Pelvic arteriogram was performed with essentially normal vasculature of the pelvis. Initial serum human chorionic gonadotropin (HCG) quantitation revealed a titer of greater than five million International Units per liter (normal value 5-30 IU/L).

Hospital Course. With the diagnosis of metastatic gestational trophoblastic disease, three drug chemotherapy was begun on Nov. 28, 1972: Actinomycin D 0.5 mg. IV, Methotrexate 15 mg. IM, and Chlorambucil 10 mg. PO planned daily for five days. Because of significant nausea and vomiting the oral Chlorambucil was discontinued, and Cytoxan 200 mg. IV was substituted for the remaining three days. On Nov. 30, 1972, whole brain and whole liver external beam radiation therapy was begun (see Figure 6). Each organ was to receive 2,000 rads (200 rads per day for 10 days). Corticosteroids were instituted to decrease intracranial edema and pressure; the steroids were gradually reduced until they were completely discontinued on Dec. 10. The status of the patient's hematologic, renal, neurologic and hepatic systems were evaluated daily. Intravenous fluids and tube feeding were required for three weeks.

An HCG titer on Dec. 8, 1972 (the sixth post-chemotherapy day) had dropped dramatically to 60,000 International Units. On the same day the white blood count dropped to 500 and the platelets to 51,000, but these returned to normal levels five days after this nadir. An HCG titer on Dec. 13 (the eleventh post-chemotherapy day) was 10,000 International Units.

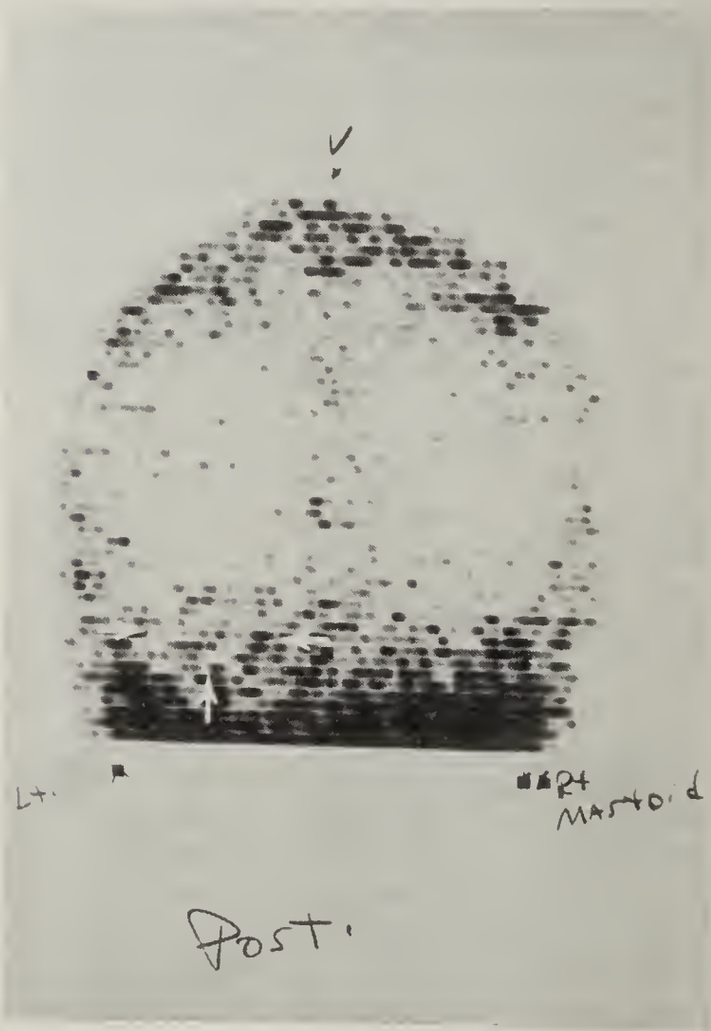


Figure 2. Rectilinear brain scan: Increased uptake in the left posterior fossa indicating a mass lesion in this region.

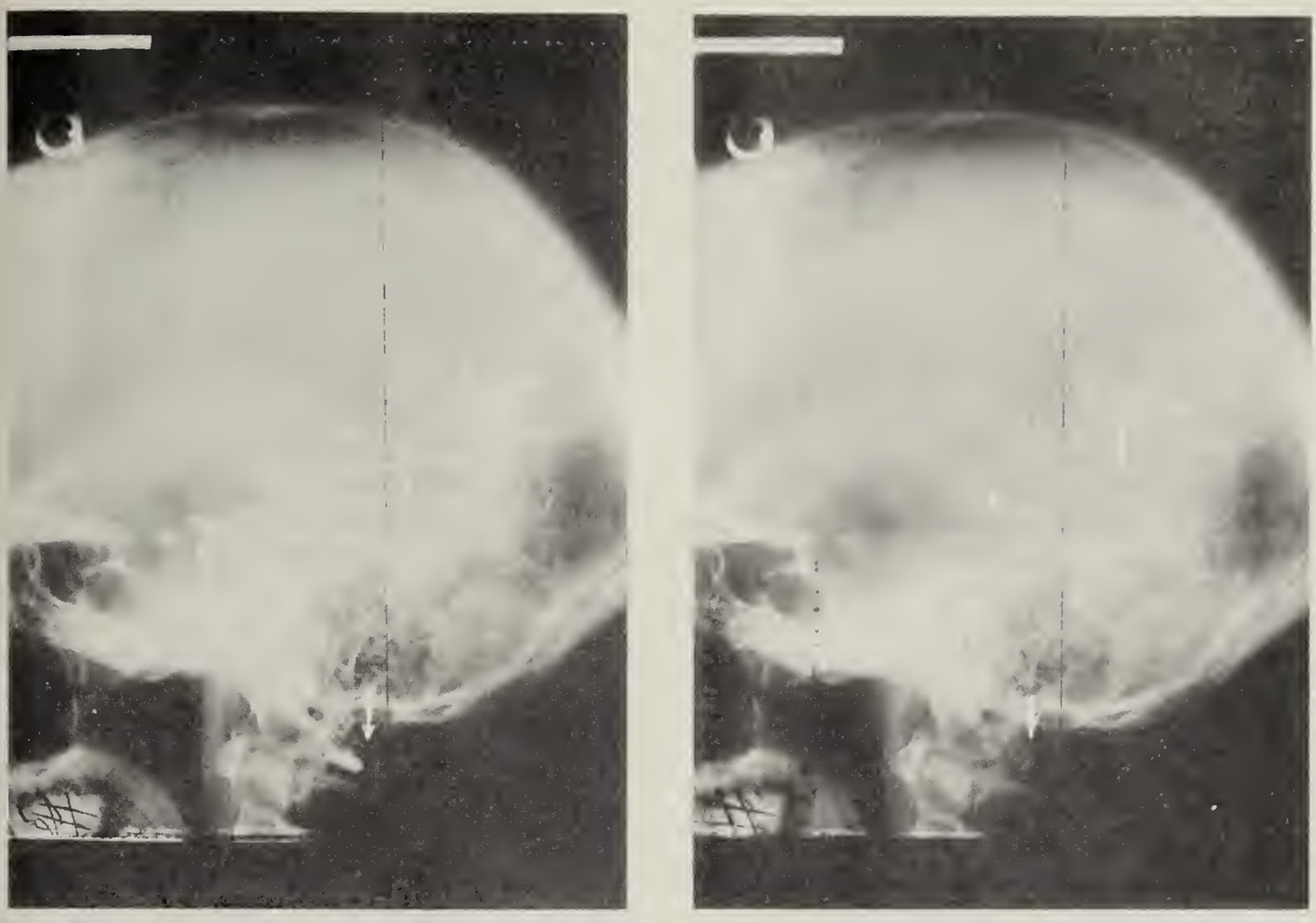


Figure 3. Vertebral arteriogram: (a) Arterial phase, left and (b) venons phase, right. Avascular mass effect within the posterior fossa demonstrated by stretching and elevation of the superior vermian artery and vein, anterior displacement of the precerebellar artery and vein, pontomesencephalic vein, and basilar artery and anterior-inferior displacement of the left posterior-inferior cerebellar artery.

On Dec. 15 (the thirteenth post-treatment day) she was started on the second course of triple chemotherapy (Actinomycin D 0.5 mg., Cytoxan 150 mg., and Methotrexate 15 mg. daily for 5 days). HCG quantitative on Dec. 19 was 2,000 International Units. The second course of triple drug therapy was tolerated well with a nadir (1100 white blood count and 78,000 platelets) on the seventh post-treatment day. An HCG titer on Dec. 27 (the eighth post-treatment day) was 250 International Units.

After two courses of triple chemotherapy, because of the dramatic response (reduction in HCG titer), single drug therapy was substituted for triple therapy. Actinomycin D (0.5 mg. IV daily for five days) was given from Dec. 31 through Jan. 4, 1973. This was tolerated extremely well.

On Jan. 11, she was started on her fourth course of chemotherapy (and second course of single drug) seven days after the last day of the third treatment course. An HCG titer on the same day was 60 International Units. This fourth course was likewise tolerated well.

An HCG titer on Jan. 20 was 35 International Units, almost compatible with a normal level. Her fifth course of Actinomycin D was begun on Jan. 20, six days after the previous treatment regimen. There developed daily temperature spikes of 102-104°F. from the first to the ninth post-treatment day and leukopenia with a nadir of 600 on the seventh post-treatment day. A chest x-ray revealed bilateral lower lobe consolidation. Intensive antibiotic therapy was instituted using Carbenicillin and Gentamycin. Numerous cultures of all organ systems revealed no growth. HCG on Jan. 30 was again 35 International Units.

Bone marrow response was slow; the white blood count was normal on the fourteenth post-treatment day. Antibiotics were continued to this point and serial chest x-rays revealed gradual clearing of the consolidation.

An HCG titer on Feb. 13 was 15 International

Units; she was discharged on Feb. 14, 1973. She was placed on oral contraceptives both to insure accurate followup with HCG titers and no intervening pregnancy.

She has now been followed for 24 months since discharge. All subsequent HCG values have been normal. Chest x-rays have remained normal with no evidence of metastatic disease. Her weight has increased to 140 pounds, scalp hair has completely returned after total alopecia, and she is without evidence of the disease.

DISCUSSION

Gestational choriocarcinoma is highly malignant and, if untreated, usually fatal. This tumor arises as a complication of conception and is derived from placental tissue elements (chorionic epithelium). While approximately 40 per cent of cases of choriocarcinoma follow hydatidiform mole, it is important to recall that 30 per cent are preceded by a spontaneous abortion, 25 per cent by a normal gestation, and a small percentage is associated with ectopic pregnancy. Thus while we are clinically alerted to the possibility of this neoplasm in patients with hydatidiform mole, we must recognize that in at least half, there has been an apparently benign obstetrical event.

Choriocarcinoma is characterized by anaplastic trophoblastic proliferation, aggressive invasion of the vascular compartment, and widespread dissemination.[9] Metastasis may occasionally be confined to the pelvis but more often there is spread to the other pelvic structures, liver, lungs, brain or abdominal viscera.[12] Trophoblast elaborates HCG, a hormone that can be measured quantitatively in the urine or serum by bio- or immunoassay techniques or by one of the conventional hemaglutination inhibition pregnancy tests.[1, 7, 9] Generally, the amount of HCG produced correlates directly with the amount of viable tumor.[5, 7] HCG determinations are essential, both in establishing the initial diagnosis and prognosis, and in evaluating tumor response to drug therapy.





Figure 4. Chest x-rays: (a) Before, left and (b) after, right. Compare initial chest x-ray (left) noting the obvious two centimeter coin lesion in the right middle lobe with follow-up chest film (right) taken three months later revealing complete clearing of the metastatic lesion.



Figure 5. Liver scans: (a) Initial liver scan (left) reveals hepatomegaly and multiple focal defects. (b) Small focal lesions persist in the followup scan (right) two months later; however the liver size is somewhat diminished.

EVOLUTION OF CHEMOTHERAPY

Prior to the 1950's, surgery—hysterectomy alone or hysterectomy and bilateral salpingo-oophorectomy—was the primary treatment, and the results were generally poor. Fewer than 50 per cent with clinically localized disease were cured. Since 1956, when Li, et al, reported complete remission with Methotrexate in several cases of metastatic choriocarcinoma, chemotherapy was emerged as the primary therapeutic modality for this disease.[8] Hertz, et al, in 1961, reported 47 per cent remissions among 63 patients with metastatic disease, treated with Methotrexate.[5] In 1965, Ross and associates reported remissions in 74 per cent of 50 patients with metastatic trophoblast disease, using Methotrexate sequentially with an equally effective drug, Actinomycin D, alternating drug if the patient was not responding or the tumor became drug-fast.[10]

PROGNOSIS CATEGORIES

Experience accumulated in the several trophoblastic disease treatment centers indicates the value of dividing patients with metastatic gestational trophoblast disease into two groups according to their prognosis.[10] The "low risk" or "good prognosis" group is characterized by: (1) initial HCG titer less than 100,000 International Units, (2) treatment initiated within four months of the antecedent gestation and (3) metastasis limited to the pelvis and lungs. With proper therapy one may expect a complete remission rate of virtually 100 per cent.[3, 4, 7] Conversely the "high risk" or "poor prognosis" patient has a high initial titer (greater than 100,000 I.U.), prolonged duration (greater than four months from gestational event), and perhaps more important, cerebral or hepatic metastasis. Early experience with single drug treatment of these cases produced a remission rate of only 20-25 per cent. Remission rates of 70-85 per cent in this group are now reported utilizing three-drug chemotherapy—Methotrexate (an antifolic acid metabolite), Actinomycin D (an oncolytic antibiotic), and an alkylating agent—and cerebral and hepatic irradiation or specific intra-arterial chemotherapy.[4, 7]

It is now recognized that remission rates approaching 90-95 per cent may be obtained by employing a very aggressive approach and by recognizing the importance of monitoring renal, hepatic and especially marrow function to avoid irreversible damage to these systems.[5] A significant percentage of the deaths reported in the earlier years of cancer chemotherapy was directly related to drug toxicity.

The case presented was in the "high risk" group by every criteria: The initial HCG titer was greater than 5,000,000 International Units, the disease was untreated for longer than five months from the apparent onset, and both hepatic and cerebral, as well as pulmonary metastasis were present. Even in the absence of histologic proof, the diagnosis of metastatic gestational trophoblastic disease (choriocarcinoma) was established by the history of recent normal pregnancy, the current clinical findings, radiographic studies and positive pregnancy test.

Currently accepted therapy for such "high risk" or "poor prognosis" patients was instituted utilizing three drugs simultaneously daily for five days: (a) Methotrexate, 15 mg. IM; (b) Actinomycin D, 0.5 mg. IV; (c) Chlorambucil, 10 mg. PO, or Cytoxan, 200 mg. IV. Radiotherapy to the brain (generally chemotherapeutic agents poorly penetrate the blood-brain barrier) and liver enhance local control and reduce the risk of hemorrhage from metastatic foci.[2] Irradiation and Actinomycin D act synergistically at the cellular level.[12]

Two courses of triple chemotherapy were given with a 13-day period between to minimize marrow suppression and hepatic and renal toxicity. Steroids reduced cerebral edema and provided symptomatic relief. After the second course, a dramatic tumor response was noted (symptomatic improvement, HCG reduced from 5,000,000 to 10,000 and clinical regression of liver, lung and brain metastasis). In view of this marked response, as well as the hazardous toxicity of triple therapy, single drug (Actinomycin D) was given for the remaining courses. Oncolytic effects were measured with weekly chest x-rays, HCG titers, and physical exams. Hepatic and renal function remained minimally impaired, but bone marrow toxicity was moderately severe. The hematopoietic system demonstrated a nadir (maximal suppression as evidenced by degrees of pancytopenia) usually on the fourth to seventh post-treatment day. An adequate recovery should be demonstrated before the next course of drug is administered.

Lutenizing hormone (LH) of the anterior pituitary cross-reacts both biologically and immunologically with HCG. Oral contraceptives were therefore prescribed to suppress the LH surge as well as to prevent subsequent pregnancy.[4, 7]

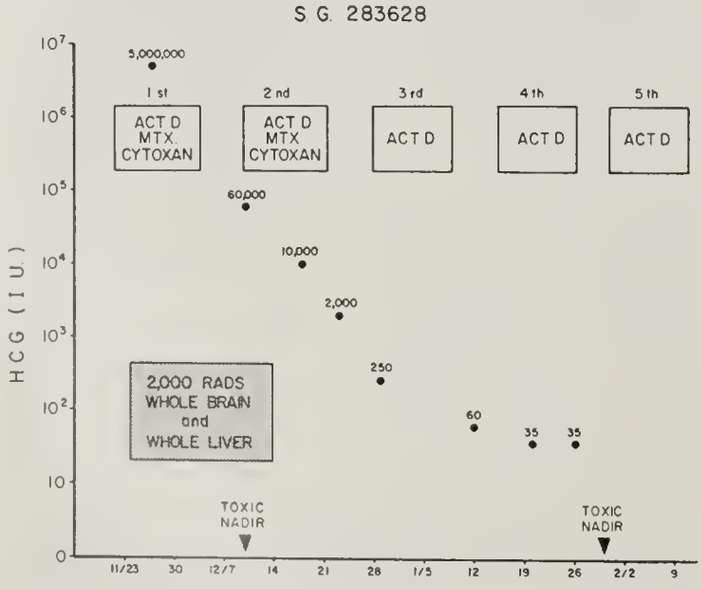


Figure 6. Schematic clinical summary: Dramatic response to therapy with progressive decline in weekly serum human chorionic gonadotropin titer.

Chemotherapy was continued with one course of drug given *after* the first essentially normal HCG determination (see Figure 6). She was then discharged and followup plans included: (1) monthly serum HCG determinations, chest x-rays and pelvic exams for 4 months, then every other month for 8 months and (2) avoidance of pregnancy for 12 months. Based on currently available followup information, the fact that this patient has had 19 months of continued normal titers suggests a probability of cure in excess of 98 per cent.

SUMMARY

The historic lethality of metastatic choriocarcinoma has been dramatically altered by modern chemotherapy. Because of this, the physician must keep these rare tumors in mind; dramatic favorable results can be obtained. Each patient must be carefully evaluated and treatment individualized, and, for patients in the "poor risk" group, especially aggressive management must be utilized. An illustrative case is presented. ★★★

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The Crisis in Health Care Delivery

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HISTORICALLY, health has traditionally been in the province of religion and the supernatural. From the earliest times, it was the priest, the medicine man or other spiritual leader who played the role of healer, and medical care was dispensed mainly on the basis of superstition. Plagues, droughts, and pestilences usually required sacrifices, either animal or human. Priests directed the construction of temples, observatories and other edifices, largely as a means of maintaining their authority over the population. At such widely separated places as Stonehenge in southern England, Chichen Itzá in the Yucatán, at various places in China and elsewhere, it was possible to predict eclipses and other celestial events with remarkable accuracy.

In America it was the medicine man, or priest equivalent, who conducted ritual dances, chants, incantations and sometimes sacrifices to heal the sick. Until very recently in the course of human events, these were the standard treatments for illness in most parts of the world. In the main, they had little or no effect on the natural history of disease.

In the Middle Ages the services of physicians were available to royalty and to the wealthier segments of society but not to members of the general population. In retrospect, this was fortunate, for in the light of present-day knowledge, most of what the doctors did was wrong. Their practice of "bloodletting" surely killed many of their patients, and they administered purges and other toxic medications that must have been more harmful than beneficial.

Presented before the Governor's Select Committee on Health, Jackson, Miss., Sept. 25, 1973. Adapted from previous addresses on the same subject delivered at the Millsaps College Forum on Sept. 15, 1972; Regional Advisory Group of Mississippi Regional Medical Programs on Nov. 15, 1972; Mississippi Chapter of Communications Workers of America on March 9, 1973; and Board of Directors of Blue Cross-Blue Shield of Mississippi on July 7, 1973.

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Then, about a hundred years ago the scientific method began to be applied to medicine. Most pathogenic bacteria were discovered between 1870 and 1880, which was within the lifetime of my father.

The author, professor and chairman of the department of preventive medicine at UMC, discusses his thoughts about health care in Mississippi and in the nation. He emphasizes the difference in demand and need for health care and discusses the factors involved in legislating a new health care system for the U. S.

The viruses have been discovered in my lifetime and we still continue to find new ones. The sulfonamides came into use when I was a freshman medical student and penicillin became available when I was a junior or senior. Immunizations, most medical and surgical innovations, and what we generally think of as modern medicine are all products of the late nineteenth and twentieth centuries.

I remember that in my boyhood I was given calomel twice a year, in the spring and in the fall. And who among my generation can fail to remember the "chill tonics," "liver regulators," mustard plasters, castor oil, "elixirs," laxatives and "pain killers" with which we were dosed all too frequently? Many are still in wide use today.

But as the scientific basis for medical practice continued to advance, society became much less tolerant of home remedies, and demands for modern medical care began to mount. With the realization that modern medicine was a positive force, and a very powerful one, in the lives of individuals, those who could not afford it began to demand its availability for everyone.

Hospitals had traditionally been places where people went to die. In a very short time they were transformed into institutions in which patients expected to recover, and a system of providing modern medical care was gradually developed. It was, however, put together in a haphazard manner that left large segments of the population underserved or unserved. The late Walter Reuther referred to it as a "non-system."

The key to access to the medical care system was money. Those who had sufficient means could buy into it, and those who did not usually had to do without.

Then, in the Eisenhower administration there was a White House Conference on Health which was attended by experts from various parts of the nation. At the close of their deliberations the conferees affirmed that every person in the United States was entitled to basic health care, irrespective of his economic status, race, color or creed. This, in effect, changed the key to access to the system from *money* to *need*. In his address before the annual meeting of the Association of American Medical Colleges a short time later Roger Egberg, then Under Secretary of HEW for Health, stated that those persons traditionally outside the health care system were now enthusiastically embracing the new philosophy that they were entitled to such care irrespective of their ability to pay. He further pointed out that it did no good for health professionals to sit around telling each other there isn't any way to give it to them.[1]

In its effort to broaden the access to medical care, the federal government gave out "chits," as we used to call them in the Navy, in the form of Medicare, Medicaid, etc. This amounted to telling a large segment of the population in the lower economic levels that "here is your ticket for medical care. Go and get it." Predictably, the delivery system was swamped. There was simply no way to accommodate so many additional consumers in such a short period of time. In a crash program to try to catch up, new medical and allied health professional schools have been built and those already in operation have been expanded. But we still license almost as many foreign medical graduates each year as we do graduates from our own schools.

Almost any thoughtful person would have to agree that the health care delivery system we now have leaves a great deal to be desired. Three years ago my department at the University of Mississippi

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Medical Center completed a survey of the health manpower, facilities and resources of the 20 counties in northeast Mississippi which are included in the Appalachia Regional Program. This study produced some interesting and disturbing findings. For example, in some of the areas surveyed as many as 40 per cent of the children 14 years of age had never been to a dentist in their entire lives. In my judgment, this means they are outside the dental care system and many are outside the total health care system as well. For many people in Mississippi and elsewhere in the nation the care available to them is either grossly inadequate or totally lacking. This must be recognized as a simple fact.

The question is, what to do about it? First, it must be admitted that a problem exists. Also, it is absolutely essential that a distinction be made between *need* and *demand*. By and large, the public, as well as those of us in the health professions, tends to confuse the two. This is most unfortunate, because they are by no means the same. Some persons may have needs they do not recognize and for which they do not seek care, while others may demand services they do not need.

Let us consider for a moment the problem of those individuals who are not getting adequate health care and who won't get it unless it is provided for them at substantially no cash outlay to them. What is it that we are, in fact, talking about when we say that we should provide these persons, along with everyone else, with "the health care they need." Some things could probably be agreed upon. Most of us would support the U. S. Public Health Service and State Boards of Health with their programs to provide clean water, clean air, sewage disposal, immunizations, etc. But would we all agree to provide free visits to a doctor or dentist? My family dentist bill last year was $2,000 for four people! It was a little less than that this year because my daughters had already acquired most of the crowns they had to have. But, when applied to the total population, we are talking about a *lot* of money! Would you provide diagnostic studies, some of which would require hospitalization? Would you provide free surgery, free medicines, and free prosthetic devices?

Suppose someone needed a special diet that was very basic to his continued good health and that he was unable or unwilling to prepare for himself. Would you be willing to pay someone to prepare it for him every day? Should a person be provided with free eyeglasses? Suppose he, or she, preferred contact lenses, which would be more expensive. Would you provide him with such lenses?

What about the case of the town drunk who ends up in the tank every Saturday night? Eventually, his doctor tells him that if he does not stop drinking he will probably lose his kidneys. In spite of this, he continues to drink and finally is brought to an emergency room some night in complete renal "shutdown." He then has to be put on renal dialysis at a cost to the taxpayers of $5,000 to $10,000 or more a year. Is he really *entitled* to this kind of expensive medical treatment at the public expense? Is this what you have in mind when you address yourself to the problems of providing basic health needs for everyone?

Let us look at some other examples. What about the man who kills himself smoking cigarettes? Even the most conservative estimates now tell us that cigarette smoking killed at least 150,000 people last year in the United States alone. Most of these persons died from heart disease caused or aggravated by smoking, and almost all of the rest died from lung cancer. *Bronchogenic carcinoma is now the most common cancer in men, and it practically does not occur at all in men who do not smoke cigarettes.* There are ample statistics to support this statement,[2, 3] but the simple fact is that cigarettes *do* kill people from a variety of causes, including these two. My question to you is this: Does a man have a right to kill himself by a slow, painful, inordinately expensive means that he cannot afford, *at the public expense?* The truth is that almost no one can afford to die with cancer. This group of diseases exacts a fearful toll in manpower and in medical facilities that often spells economic ruin for the patient and his family.

Or what about the person who determines to kill himself with alcoholic cirrhosis, which is also a very expensive way to die? Or, does a person have the right to addict himself to a drug at society's expense, or to kill himself from hypertension by overeating?

In short, *is any individual in our society "entitled" to do whatever he pleases if it can be shown that by doing so he materially increases his risk of serious illness at the public expense?* Someone has to answer this question before the health planners can even approach the problem of delivering health care. And it has to be answered in the full knowledge and realization that *most of the ills from which we now suffer are the result of something we do to ourselves.*

Man is, after all, a human animal. He got to be what he is over many, many thousands of years. To survive he learned to cope with an essentially hostile environment. In the process of becoming an efficient hunter he sharpened his thought processes and de-

veloped a high degree of physical agility and stamina. He was constantly on the move, often covering long distances on foot. Primitive tribes still live this kind of existence, but elsewhere man has become more "civilized."

How has he fared in the societies he has created for himself at such monumental effort? To begin with, his lifestyle has changed profoundly from that of a hunter to a basically sedentary existence. He will wait five minutes to ride an elevator down one flight of stairs when he might walk down in a minute. In truth, he walks almost *no* place and takes almost no exercise of any kind. If he moves around enough to sweat it is usually because the air conditioner broke down. His wife has to have a 4,000 pound automobile to drive two blocks to the corner drugstore to get a hairpin. Manual labor is almost a thing of the past. Technology has virtually done away with it.

The air he breathes is generally polluted. The total environment is, in many cases, grossly contaminated. He ferments anything with sugar in it and gets drunk off the alcohol. He eats five to seven times a day and consumes animal fat all his life. Instead of fruits, vegetables and lean meat, he eats ice cream, cream, cheese, eggs, bacon, candy, cakes, cookies, spices, pepper, pies, etc., virtually none of which were accessible to him throughout the hundreds of thousands of years when he was basically a hunter. And he eats too much of everything. He drinks a pint to a quart of coffee a day to stay awake, keep his head reasonably clear and cut down on his appetite. He takes sedatives and tranquilizers at night to try to relax and get some sleep. He may work at night and not be able to sleep in the daytime. He takes an unbelievable amount of medication. Just turn on the television set some night and look at the advertisements for headache pills, antacids, laxatives, decongestants, cough syrups, deodorants, tranquilizers, etc. Almost everyone routinely takes several kinds of medicines.

Civilized man worries about his wife, his children, his income, job, home, security, keeping up with the Joneses, and his own ulcers. His blood pressure is high and his serum cholesterol is elevated. He is overfed, overweight, underexercised, tired and subjected to constant tension.

I think it is worth noting that in the year 1972 alone, almost forty million pounds (40,000,000 lbs.) of chlorinated hydrocarbon and phosphate insecticides were used in Mississippi. Three counties in the state (Bolivar, Sunflower and Washington) had an average of 96.6 pounds of insecticides, herbicides, and defoliants dumped on them for every man, woman and child in the counties![4] The Sunflower River, which drains much of this area, is quite possibly the most heavily contaminated with insecticides of any river on earth.

The World Health Organization (WHO) has recommended a maximum level of DDT in cow's milk of 0.05 parts per million of whole milk and 1.25 ppm of butterfat,[5] and the Food and Drug Administration has adopted this as the legal maximum in the USA.[6] Yet recent preliminary studies in Mississippi in areas of high pesticide usage have revealed levels of DDT in the fat content of the milk of lactating women that are almost 40 times this maximum![7] If it were cow's milk it could not be sold on the open market. If subsequent investigations confirm the extraordinarily high levels found in this pilot study, it will be imperative that a full evaluation of the effects of such concentrations of these chemicals on health be undertaken.

From eating and drinking his own raw sewage modern man gets 75 or more enteroviruses, including the Coxsackie and ECHO viruses. He also gets amebiasis, typhoid, salmonella and shigella infections, cholera, hepatitis, ascariasis, strongyloidiasis, and pinworm infections, to name a few.

From overcrowding he gets tuberculosis, streptococcal infections, measles, mumps, whooping cough, diphtheria, and a host of respiratory diseases, not to mention psychological and psychiatric problems.

From salvaging the genetically defective, he develops in the population ever increasing percentages of mongols, diabetics, mental defectives, phenylketonurics, sickle cell anemics, and persons with a whole host of polycystic, metabolic, neurologic, anatomic, and possibly neoplastic diseases.

These are the people who make up the vast majority of patients in doctors' offices and hospitals today. Most of their illnesses are difficult or impossible to treat satisfactorily but *almost all are partially, if not totally, preventable.*

Again, we are faced with the question, "What health care do these people need?" Or, stated another way, "What should we expect from our health care system?" I recently lived for a year in Japan and the Far East as a visiting professor in several medical schools. Senior citizens in the Orient are venerated in ways we don't even begin to understand in this country. There is not a member of a family in Japan who would not make *any* sacrifice or perform *any* service that would contribute to the

well-being or comfort of an older person in that family.

In the West we seem to have a different philosophy. Old people are a lot of trouble. They soil their clothes, they soil their beds, they cough up things, they won't bathe or in many cases can't bathe themselves. They need a lot of medicines, they are sometimes incoherent, they often have to be fed, have to be nursed, and some of them can't be left alone for more than a few minutes. Our answer to these people and their needs, more often than not, is to put them in a nursing home or hospital "where they will be taken care of." This is not always done just because it is troublesome to have them at home. The economics of the American family now frequently dictate that both the husband and wife must work and there is simply no one at home to look after a senior citizen. But are we to include extended nursing care in the list of health needs to which senior citizens are entitled? Is an individual "entitled" to spend a month or a year or several years dying in a hospital when he could just as well die at home?

Except in case of sudden death due to accident or heart disease, life can now be sustained far beyond any period of productivity, but almost always *at costs that increase exponentially with age*. I know of a man who was run over and knocked unconscious while walking across a street intersection. He never regained consciousness but *lived seven years in a coma*. Is it every individual's right to have his life artificially supported, with no hope of recovery, for as long as seven years?

When we look at the problem in terms as broad as these it becomes perfectly clear that we cannot possibly ever meet all our health needs. So, we are forced into a set of priority judgments, all too often based on what can be accomplished. The real need may be for something that is so expensive or so difficult to achieve that it is put aside in favor of something more attainable.

In spite of the vast sums of money being spent on health, it still has a relatively low priority. Health has to compete with national defense, education, housing, transportation and all the other items in federal and state budgets. This year the state of Mississippi is spending $9.00 *per capita* on its formal health programs.[8] Nationwide, 7.4 per cent of the GNP, or $358.00 *per capita* per year is spent on health.[9] For most of us, $358.00 is approximately equal to two payments on an automobile. If you calculate the purchase price of your car, cost of gasoline, oil and tires, plus your insurance premiums it becomes apparent that health is pretty far down the list of priorities. There is not the slightest doubt in my mind that if our State Board of Health had in its budget the $600,000,000 that has been set aside for the highway program in Mississippi, we would have a health care system that people from all over the world would come to look at. But the people, through their elected representatives, have said that highways are more important. I accept that and I might even have made the same judgment, but it illustrates the fact that health is *not* our first consideration. We often fail to recognize this at the very time when we are demanding increased health care benefits, and many of us in the profession fail to appreciate the fact that *our* top priorities are not necessarily the same as those of the general public.

Much has been said concerning the shortage of physicians and we are constantly being reminded that their distribution, both geographically and by specialty, is not optimal. The question of a doctor shortage is, at least in some measure, a matter of definition. As long as we continue to license several thousand foreign medical graduates each year it can be argued convincingly that we are not graduating enough from our own schools. Pragmatically, we may already have about as many doctors, nurses, and other health professionals as the economy can support, but if *need* is the criterion by which adequacy is determined then we remain critically short of medical manpower.

Nor is it likely that the admitted maldistribution of physicians and other members of the health team will be easily corrected. It is a hallmark of our society that every individual is free to live and work wherever he pleases. If he chooses to live in New York City, or on an Iowa farm or in the mountains of Wyoming he is free to do so. What he is now trying to do is to devise some means of enticing (or forcing, if it comes to that) his doctor to make the same choice he has made. Those areas that are less attractive to medical practitioners are served, in most other countries, by some form of conscription of doctors for one or more years after they graduate from medical school. There are clear signs that we may be coming to this in the USA.

A rural practice can be extremely demanding. Transportation for both the doctor and his patients can be difficult and time consuming. My father-in-law was a general practitioner in Thornton, Mississippi, until his untimely death at a relatively young age. His demise was hastened by the fact that he rode on horseback from one plantation to another, in all kinds of weather, by day and by night to treat people who had no way to get to his office.

A rural practice is not only physically demanding, but there is often no way to get away from it. In a farming community the patients begin calling at about 4:00 o'clock in the morning, which is when they get up. On Sundays a doctor may have to leave home to get a few hours rest. I have a friend who did general practice for five years before going into academic medicine. He tells me that on Sundays he had to put his car out of sight, close the doors, pull the shades down and keep the children out of the yard in order to keep from having to hold sick call throughout the day.

Rural practitioners have less opportunity for consultations with other doctors and there may be no hospital in the community in which they practice. The schooling available to their children is often not as good as in a larger city. Small communities have no symphony orchestra, no opera guild or little theater, no civic auditorium or arts center, no coliseum with its annual arts festival, no medical library and possibly no public library; no shopping malls, no specialty restaurants, theaters, etc. In short, the cultural life is minimal or nonexistent.

So, the total medical demands of the nation can *never* be met and neither probably can the actual needs. But demands are being voiced by the have-nots who are not interested in *whether* the care can be delivered or *whether* the bill can be paid, or by whom. The governor of a wealthy mid-western state once told a colleague of mine that he had reached the conclusion that the demands of higher education were insatiable. The same is probably true of medicine. We simply cannot be all things to all people. We are going to have to make some hard priority judgments with respect to what we *will* plan for and pay for and what we *won't*. In my judgment, there is not likely ever to be a country in which any individual can be given any kind of health care he thinks he needs, anytime he wants it. The cost would simply be prohibitive. And the public has to be told this!

Medicine is not society's only priority, or even its first. Are "free" operations, medicines, dentures, eyeglasses, corsets, diets (we are already providing free school lunches), etc. more important to the people than education, the national defense, art, literature, transportation, air conditioning, heating and all the other acoutrements we need and want? In short, what per cent of the GNP do you want to assign to health? Many experts believe that 8 per cent of the GNP is about the maximum that society will spend on health in this country, and we are rapidly approaching that figure. But 8 per cent will come nowhere near meeting the cost of the rising expectations of the poor and near poor who have been told they are entitled to whatever they need, and have been promised they will get it.

We can have any level of health care we want and I am sure we can have it more efficiently and more equitably distributed than it now is, but let's not look for it to be any cheaper. Personnel, equipment and supplies are all *in*creasing in cost. Even if we are able to improve our efficiency in delivering health services, we may soon discover that we are insisting upon a level of care that cannot be afforded for everyone.

The decade of the 70's has brought medical education and the health care system face to face with the most complex problems and urgent demands they have ever known. The value of good health and the power of medicine to promote it is known to almost everyone and no segment of society will henceforth tolerate being deprived of it without voicing the most strenuous objections. The machinery of government and the people at large are joined in a call for more and better health care for everyone, regardless of race, color, creed or economic segment of society, yet large groups within the population are, as they have always been, partly or completely outside the system of health care delivery. Attempts to purchase medical care for the indigent poor within the present system are proving so costly they cannot be rationally defended. Whether to continue with these efforts or to devise a new, more efficient system built upon a team approach and utilizing a broad spectrum of allied health professionals is one of the greatest issues now before the American people.

I think the public is not nearly as aware as it should be of the frustrations thrust upon our decision makers. Members of state legislatures and of the Congress are called upon to make judgments with far-reaching consequences. You represent an intelligent, highly educated sector of society which ought to be better prepared than most to exercise judgments of this magnitude. Be assured that if your horizons are not distant enough or your vision not clear enough, plans *will* be made and actions *will* be taken by others who are less well qualified. Let us hope that we can all work together for a fuller, healthier life for everyone. ★★★

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107th
ANNUAL SESSION
OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION

May 5-8, 1975
at the
Sheraton-Biloxi
Biloxi, Miss.

Scientific Sections
Annual Meeting of the House of Delegates
Scientific and Technical Exhibits
Social and Alumni Occasions

Radiologic Seminar CXXXXIX: Mammography

JOHN Y. GIBSON, M.D.
Jackson, Mississippi

MAMMOGRAPHY is a method of plain-film radiography of the breast using a specialized soft tissue technique. It differs from conventional radiography in two respects: (1) The x-rays used are generated at a very low kilovoltage (20-35 Kvp.). (2) Special fine-grain film of the "industrial type," which has a high inherent contrast and resolution, is used to produce the image of the breast tissues.

Mammography gained widespread recognition in 1960, upon publication of the results of clinical research conducted by Dr. Robert Egan,[1] who was then a staff radiologist at the M. D. Anderson Hospital and Tumor Institute and is now a Professor of Radiology at Emory University School of Medicine in Atlanta. Dr. Egan had devised a safe and practical method of radiographically examining the breast which proved 80 per cent to 90 per cent accurate in detecting cancer. More than that, his research revealed that mammography could detect cancer in the breast before any symptoms or physical signs of disease were apparent to the patient or to her physician (10 per cent in his series and 30 per cent reported recently by Wolfe[2]). Since the breast was then and still is the most common site of cancer in women, the fact that mammography could detect "occult" malignancy captured worldwide attention.

In the past 14 years further improvements in techniques for imaging the breast have developed such as the use of vacuum cassettes with improved film to further increase the detail and xerography, a system which converts the x-ray image to an electrical one and then imprints a "picture" of the breast on specialized paper.[3]

The most pertinent question for a nonradiologist is "when is mammography indicated?" To properly answer this question certain facts must be considered. Obviously any person (male or female) who has symptoms or signs of breast disease such as a palpable lump, retraction, bleeding or discharge of the nipple, skin thickening or the development of an enlarged axillary lymph node should have benefit of x-ray examination of the breast. But what about the fact of mammography's ability to detect occult malignancy? Should not every woman have a mammogram? Probably not, simply because current facilities and personnel could not meet the demand and mass screening of asymptomatic patients has previously produced a low yield.

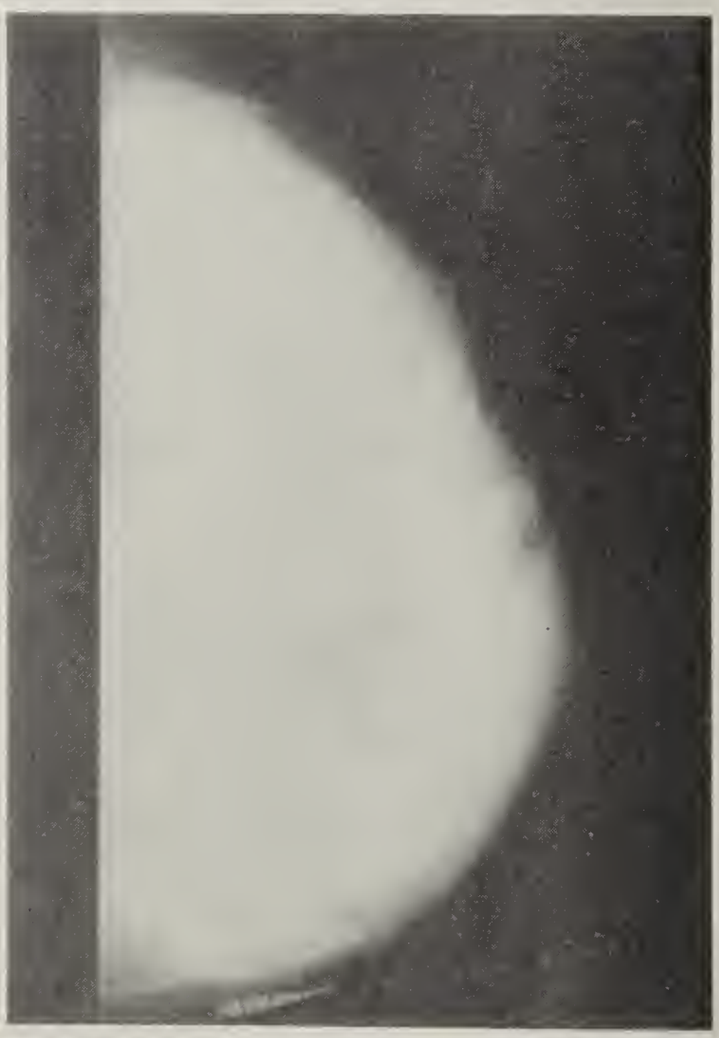


Figure 1. Adolescent breast showing the almost uniformly opaque density due to the high percentage of glandular tissue relative to fat.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi Medical Center, Jackson, Miss.



Figure 2. Postmenopausal breast showing the large amount of radiolucent fat and little glandular tissue.



Figure 3. Lobulated nodule (arrows) with slight tissue reaction. Pathologic diagnosis: Adenocarcinoma.

However, certain high risk groups should have an annual mammogram. These are: (1) any woman over 35 years of age who has a sister or mother with proven breast cancer since studies show a significantly higher incidence of cancer of the breast in these patients than in the average female population. (2) The woman who has had one breast removed because of cancer has a 15 per cent incidence of the development of a secondary primary cancer in the remaining breast (Happy Rockefeller is a recent notable example) compared to a 1.7 per cent incidence of breast cancer in the average population. Also a woman whose breasts are constantly lumpy from known fibrocystic or other benign disease and those whose breasts are too large to adequately examine should have periodic mammography. The women who have undergone augmentation mammoplasty need to follow only the guidelines for her age group since there is no evidence of increased incidence of cancer of the breast in this group and since physical examination is not hindered by the presence of the prosthesis. Women who have proven adenocarcinoma originating from an unknown site should have mammography to exclude the breast as the primary site of malignancy.

It needs to be restated here that every woman above the age of 25 should examine her own breasts at regular monthly intervals and have semi-annual examinations by her physician regardless of what risk group she falls into (95 per cent of all breast lumps are found by the patients themselves and not by their physicians). Her own physician or the local chapter of American Cancer Society can instruct her in this most vital procedure.

The radiographic appearance of the normal breast varies considerably with age. The young adolescent breast (see Figure 1) appears as a dense mass of tissue with very little demarcation of individual structures. This almost uniform density results from the relatively large amount of dense glandular tissue compared with the less dense fat and interstitium. With increasing age and parity, the ratio of glandular to fat tissue becomes gradually reversed and approaches the appearance of the postmenopausal

breast which is almost uniformly radiolucent due to the large amount of fat and the very small amount of glandular tissue (see Figure 2). The density of the young breast makes visualization of masses within the breast difficult-to-impossible but, fortunately, the incidence of malignancy in this group is low. In patients with fibrocystic disease the breast is homogenously dense and has a ground-glass appearance so that in a patient 30 years old who has had several children, an adolescent-appearing breast on mammography should be interpreted as indicating fibrocystic disease. Benign masses such as fibroadenomata and solitary cysts usually have smooth, well defined, circumscribed borders with little if any surrounding tisue reaction.

The signs of malignancy fall into categories of primary and secondary. The primary signs of malignancy are: (1) lobulated nodule with sharp, well defined margins (see Figure 3); (2) localized poorly circumscribed mass density with irregular or spiculated borders; (3) diffuse density; and (4) fine calcification appearing as grains of sand which are usually so numerous as to be uncountable but remain within a rather localized area. This type of calcification can be seen either with or without an associated mass. In Wolfe's series[2] the presence of calcifications in the absence of a visible mass occurred in 37 per cent of occult lesions compared to only 6 per cent of palpable carcinomas. The secondary signs are: (1) nipple retraction, (2) skin thickening and/or retraction, (3) unilateral ductal prominence, and (4) unilateral enlargement of mammary veins. All of the secondary signs can also be seen with normal breasts or in the presence of benign disease and are therefore not specific and should, when occurring alone, be regarded as only "suspicious for malignancy." The primary signs, however, are more specific and should lead to the radiographic diagnosis of "probably malignant." If clearly benign pathology exists the impression should reflect benignancy and when possible the most likely histology such as "fibrocystic disease" or "fibroadenoma." Frequently masses are detected which are neither clearly benign nor strongly suspicious for malignancy. These should be considered "indeterminent" lesions and biopsy should be recommended.

The accuracy of detecting malignancy of the breast by mammography varies somewhat with age. Egan's report of 1,580 mammograms showed an accurate diagnosis of malignancy in 50 per cent of patients under 30 years of age, 55 per cent in ages 30 to 45 years, 77 per cent in 45 to 60 years and 90 per cent in those over 60 years of age. The more recent publication by John Wolfe[2] of Detroit using xerography on 462 breast cancers reported a 95 per cent accuracy overall (percentages were not broken down as to age group).

SUMMARY

Mammography is the only reliable means of detecting cancer of the breast before signs or symptoms appear. All women 25 years and older should examine their own breasts each month and undergo semiannual breast examinations by their physicians. All persons with signs or symptoms of breast disease should have mammography. Annual mammograms should be performed on all women over the age of 35 who are in the high risk groups or have breasts which are difficult to examine because of size or known benign disease. The primary and secondary signs of malignant disease are discussed and several examples are shown. ★★★

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St. Paul Announces Policy Change

St. Paul Fire and Marine Insurance Company has announced a major policy change in its medical liability insurance program in Mississippi and other states.

Effective June 30, 1975, St. Paul will only offer "claims-made" policies for new and renewal business in the state. A claims-made policy covers claims on incidents reported while the policy is in force. Present policies cover claims reported any time in the future and are called "occurrence" policies.

Also effective June 30, 1975, St. Paul will provide its policyholders the option of buying in three annual installments a "reporting endorsement" when they retire or otherwise cease being insured which will take care of all remaining exposure to claims arising from acts performed while claims-made policies were in force.

St. Paul stated the alternative to claims-made coverage was completely abandoning the medical malpractice market. Rates for claims-made coverage may be lower initially reaching an "occurrence policy" rate by the fifth year. "In the long run," the company said, "the claims-made policy may cost the physician more because our pricing will be more accurate. . . . On the other hand, if the frequency and severity of malpractice claims stabilize, rates will stabilize."

HEW Requests Health Service Areas

In a letter to Governor Waller and other state chief executives, Secretary of HEW Caspar Weinberger has requested designation of health service areas within each state by May 3, 1975. As outlined by Weinberger, HSAs must meet the following criteria:

* A geographic region appropriate for effective planning and development of health services;
* A population of not less than 500,000 or more than three million except under circumstances approved by the Secretary of HEW;
* An area appropriately coordinated with PSRO and present planning areas; and
* An area with at least one center which provides highly specialized health services.

After designation of health service areas, health service agencies are expected to be funded. They will be responsible for development of health service plans, reviewing all proposed federal health project plans, assisting state planning and development agencies in reviewing health services and faculty needs, and preventing unneccessary duplication of health resources.

Weinberger told the governors that they are required to consult with comprehensive health planning agencies, state regional medical programs, interested health groups, and political agencies in proposing health service areas.

SBH Issues PA Policy

The Mississippi State Board of Health, acting as the responsible state agency for enforcement of the Medical Practice Act, has adopted an official position relative to the utilization of physician assistants by physicians in the state.

Under the SBH policy the physician-patient relationship can only be established by a licensed physician and the physician is responsible for all professional services provided by his physician assistant. Additionally, the physician must be present on each patient service visit except that he may delegate by telephone within the community certain authority that clearly is within the competence of the physician assistant.

MSMA and the SBH have jointly sponsored legislation in the 1975 Mississippi Legislature to authorize and require the SBH to certify the use of a physician assistant. Under the legislation a physician proposing to use a PA would submit application to the SBH outlining the PA's training, experience, and proposed functions. Based on training and experience, the PA could be certified to perform certain functions under supervision of his physician employer.

Ophthalmology Course Set for Lexington

A course on current concepts in ophthalmology and neurophthalmology will be offered April 10-11 at the University of Kentucky College of Medicine Continuing Education Center for Health Sciences.

Registration fee for the course is $80.

For further information write Dr. Frank R. Lemon, College of Medicine, University of Kentucky, Lexington, KY 40506.



The President Speaking

Continuing Medical Education

J. T. DAVIS, M.D.
Corinth, Mississippi

THE PROGRAM of continuing medical education of which you have heard so much during the past two years continues to grow and expand. Three thousand six hundred and seventy seven (3,677) courses offered by 876 institutions in 44 states and the District of Columbia have been scheduled for the 12 months—September 1, 1974, through August 31, 1975. This is a major increase over the number of courses offered during the preceding 12 months.

The courses are offered to those interested in continuing their medical education and designed to improve the competence and skill of the physician through formal presentations and other organized activities. No one need travel more than 200 miles to attend the courses of his choice, given by an organized teaching group or by the faculty in a medical center.

The need for a continuing medical education program has long been recognized. The rapid advances in scientific medicine during the past two decades have produced an overwhelming mass of data and medical knowledge. For the busy private practitioner to keep abreast is almost beyond human endeavor.

Too, during the past decade, the entry of the third party into the health care field and the intrusion of the federal government into the private practice of medicine have further usurped the physician's time and left him groping in a quagmire of legislative regulations, red tape and paper work (such that the process will soon defeat the very purpose for which the federal program was originated—the delivery of quality medical care).

Never before has the physician's time been more valuable, requiring strict budgeting to allow ample time for his patients' care. The demand of today that he deliver quality medical care, document that care with complete records in the hospital, participate in civic affairs of his community as well as fight for his life in the political arena, is a full time job and leaves little time for continuing education, family life, or recreation.

However, to survive, continuing medical education must be wedged into that already overcrowded budget. Eleven states have adopted programs requiring continuing postgraduate work as a condition of membership. Many specialty societies are in the process of instituting similar obligations on members. Four states now require continuing education as a part of the process of reregistering the license to practice medicine.

(Please turn to page 82)

JOURNAL OF THE
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MARCH 1975

EDITORIALS

Is the Past Relevant to the Present or the Future?

Since the only truly workable reality is the present, why bother about the past? Why be a "student of history"? One reason, not necessarily foremost, is that the study of history is fun. Many pleasant hours can be spent reading about the events of the history of medicine and in particular about the people who have been a part of these events. I do not believe, as some do, that it is people now famous who have made history but rather that history has made certain people famous. If the Curies had not discovered radium, some one else probably would have at about the same time. Had Wilhelm Roentgen not discovered that unknown form of radiation that sometimes bears his name, someone else surely would have. My study of history tells me that when the climate is right for a particular discovery it will happen and the person or persons caught up in such a discovery are those who are at that particular time engaged in the pursuit of knowledge in that particular discipline of science. How else can we explain simultaneous discoveries occurring in different parts of the world?

When the body of scientific knowledge has reached a particular "critical mass" a new idea is born and sometimes the explosion is devastating, not only to the unsuspecting large audience of the rest of the world, but frequently to the individual who makes the discovery. As in the case of Ignaz Semmelweis it can be so devastating as to ultimately destroy the individual. Those of you who have enjoyed Morton Thompson's "The Cry and the Covenant" will recall that in the 19th century Semmelweis discovered the simple truth that physicians performing post mortem examinations on the bodies of women dying of puerperal fever were transferring the disease agent by their own hands to living mothers they attended at childbirth. He established the practice of washing one's hands with an antiseptic solution before delivering a baby, but he was so tormented by his colleagues who were insulted by his urging them to wash, that he eventually was driven out of Vienna. He died in despair infected by the same organism he had fought so diligently to eliminate. His son so loved his father and was so distraught in subsequent years over the lack of acceptance of his father's theories, that he killed himself at the age of 25. Joseph Lister later wrote "Without Semmelweis my achievements would be nothing. To the great son of Hungary surgery owes most." So we see that history is not always merciful to its sons and daughters, but it does seem to reveal to us when we are ready the truth we consciously or unconsciously seek.

Another sound reason to study history is to establish a sense of place. Inherent in man's uneasiness about himself is the need to search for knowledge that will provide a more secure sense of belonging. To gain awareness of what came before is to grow in the security of knowing why we are as we are and why we do what we do. Present day physicians and scientists have inherited a vast body of knowledge that was born of the sweat and heartbreak of those who came before. Learning the circumstances and events surrounding many of the discoveries provides an understanding of just how much our predecessors gave of themselves to provide knowledge we so often take for granted. An example interesting to me is the first accurate description of the physiology and anatomy of the pulmonary circulation. To properly set the stage for describing such a drama, I will give a brief background. In the second century A.D. Galen provided a not only inaccurate, but quite confusing

explanation of the physiology and anatomy of the pulmonary circulation. He believed that a portion of the blood from the right ventricle was carried to the lungs by way of a vessel we now call the pulmonary artery. The rest of the blood he thought passed through pores in the interventricular septum into the left ventricle where it mixed with "pneuma" from the lung to form the "vital spirit." This pneuma came to the left ventricle by way of the pulmonary veins, but whether it consisted of inspired air or something derived from it is uncertain. From the left ventricle the "waste vapors" were returned to the lungs through the same pulmonary veins so that Galen was at least on this point committed to bidirectional flow in the pulmonary veins. His view of the pulmonary circulation was to remain authoritative in medical teaching for the next 1400 years. In the latter part of the 16th century Vesalius, the father of modern anatomy, was to be virtually driven out of academic medicine because he contradicted some of the teachings of Galen. Although there is some evidence that in the 13th century an Arab in Cairo by the name of Idn-An-Nafis actually was the first to correctly describe the anatomy and physiology of the pulmonary circulation, credit is usually given to a Spanish physician named Michael Servetus (1509-1553). In one of his religious books "Cristianismi Restitutio" (The Restoration of Christianity) in order to support a theological argument (since he did not separate science from religion) Servetus accurately described the pulmonary circulation. He reported that blood does not pass through the interventricular septum ("a truth unknown to Galen") but rather passes to the lungs through the pulmonary artery which, as he stated, would not be "of such size nor emit so great a force of pure blood from the heart itself into the lungs merely for their nourishment." In the lungs where the blood turns "a crimson color" as it is "mingled with inspired air and becomes a suitable home of the vital spirit, it is attracted at length into the left ventricle of the heart by the diastole of the organ." Servetus considered the "vital spirit" to be the divine spirit of God. Because other views he stated in this book were in direct conflict with those held by men in positions of power, particularly John Calvin, Servetus was arrested in 1553, prosecuted for heresy and condemned to death. At the age of 43 Michael Servetus was burned at the stake with copies of his "Cristianismi Restitutio" contributing to the fire. All but two copies of the book were destroyed, the extant ones being some of the rarest books of the Renaissance.

Such is the nature of our great heritage of knowledge. Why indeed bother about history? The reasons seem clear; to learn what we have been in the past, who we are now and what we must strive to be in the future.

John Y. Gibson, M.D.
Jackson, Miss.

Medico-legal Briefs

INVOLUNTARY COMMITMENT STATUTES HELD INVALID FOR VAGUENESS

Several statutes on involuntary commitment of mental patients were unconstitutional, the highest court of West Virginia ruled. The statutes provided for commitment on the ground that the patient needed "custody, care or treatment." The "custody, care or treatment" provision was unconstitutionally vague, the court said. In addition, the statutes did not require that the patient be present at the commitment hearing, a right to which the patient was held entitled.

A patient at a state hospital brought a habeas corpus proceeding before the high court to challenge the validity of the commitment statutes. He had been committed in 1969 after two physicians certified that he was mentally ill and dangerous to himself. A hearing had been held, but he had not been present. Only the physicians' reports had been presented, and an attorney had been appointed as the patient's guardian without the patient's consent.

In an opinion condemning the conditions in West Virginia mental institutions, the highest court of West Virginia stated that it could not tolerate the paradox of depriving mental patients of their civil rights in the name of hospital treatment and then offering those "unfortunates who are incarcerated in mental institutions Dickensian squalor of unconscionable magnitudes."

Permitting involuntary hospitalization of a patient in need of "custody, care or treatment" was improper because it was vague, set no specific standards and was subject to abuse, the court said. However, involuntary commitment for patients likely to injure themselves or others was constitutional. The state was entitled to protect itself from dangerous persons, the court said.

Continuing its attack on the West Virginia commitment laws, the high court ruled that permitting commitment hearings in the absence of the patient and not bound by the rules of evidence denied a

patient's right to confront and cross-examine witnesses. The right to confront witnesses exists in all cases involving deprivation of liberty, not just in criminal cases, the court continued.

Statutory provisions requiring notice to be given to a patient were constitutional but were not followed in this case. The patient received only notice that a hearing was to be held. He was not informed of the nature of the proceedings, the allegations against him, or his right to counsel at every stage of the proceedings except during examination by a physician.

Ruling on some final contentions by the patient, the highest court of West Virginia said that the proper standard of proof in an involuntary commitment was "clear and convincing," not "beyond a reasonable doubt" as the patient claimed. The patient's right to a judicial review of the commitment proceedings was violated because no transcript was kept. A verbatim transcript was necessary to provide a meaningful review.

The court concluded by granting a writ of habeas corpus discharging the patient from custody and restoring his full civil rights.—*State of West Virginia ex rel. Hawks v. Lazaro,* 202 S.E.2d 109 (W.Va. Sup.Ct. of App., Jan. 15, 1974)

LETTERS

SIRS: We would like to invite our medical colleagues to become members of our national nonprofit organization which is dedicated to furthering art interests of the medical profession; to broadening the physician's knowledge and appreciation of the past and present; to stimulating physician artists to produce works of art in the fields of painting, sculpture, photography, graphic arts, design and creative crafts; to holding a national annual exhibition of physicians' art works; and to stimulating regional art exhibitions of physicians' works at local, state and specialty meetings.

Our art exhibit is held annually in conjunction with the annual meeting of the American Medical Association. The APAA has a membership which extends across the entire United States, Canada and Latin America. Every state in the union is represented through a regional director. It is the hope of the APAA to establish a central photographic archive of its members' art works, to be used for year round press and magazine publicity in the physicians' home towns as well as nationally.

You do not necessarily have to be currently engaged in any art activity to become a member. We also welcome the support of anyone interested in furthering physicians' art in America, as our organization is totally supported by the members and friends of the APAA. The types of membership are:

Life Sponsor Membership	$200.00
Sponsor Membership	30.00
Regular Membership	15.00
Associate Membership*	5.00

If you are interested in becoming a member, or if you wish further information, please contact me at 3270 Green Road, Cleveland, Ohio 44122.

VICTOR C. LAUGHLIN, M.D., F.A.C.S.
President

SIRS: The existence and consequences of emotional and psychological illness in physicians, as well as of pathological conditions that may impair the doctor's judgment and skill, are issues of paramount concern to the medical community.

Organized medicine, by virtue of its professional commitment to the public welfare, must now work toward developing a more viable strategy of identifying and guiding those physicians who have become disabled because of mental disorders, alcoholism or drug dependence.

The American Medical Association, through its Department of Mental Health, will sponsor this spring a milestone national conference dealing with the disabled physician. We sincerely hope that many of you can attend.

This meeting will be held in San Francisco at the St. Francis Hotel on April 11-12. It will focus on the issues of motivating the disabled physician to seek advice and treatment, and exploring alternative procedures to insure the effective treatment, rehabilitation and disciplinary action, when necessary, of the disabled physician.

Another charge of the conference will be to examine various options for legislative support, including AMA's "Disabled Physicians Act." As many of you may know, the AMA has developed model legislation in the form of a uniform state law. The approach taken through this draft bill is preventive rather than punitive. What is really intended is to find and treat the physicians with these kinds of disabilities.

Failing other more informal procedures, the model legislation provides for restriction, suspension or

* Associate Membership is for medical students, interns and residents.

LETTERS / Continued

revocation of a practitioner's license for reasons arising out of physical or mental illness.

Alcoholism and drug addiction in physicians, for example, often emerge as problems of significant human tragedy and professional devastation. Now is a critical point in medical history for us to *assume* and *exercise* our full responsibility in providing competent care to patients. Accountability within the profession's ranks and, more importantly, for the public welfare has long been organized medicine's professional commitment as the healers in society.

Therefore, we hope you can participate at this landmark meeting. For more specific information concerning the conference, we urge you to contact AMA's Department of Mental Health, 535 N. Dearborn, Chicago, Il 60610.

MALCOLM C. TODD, M.D.
President, AMA

DEATHS

LAIRD, JOHN ROBERT, Newton. Born Union, Miss., March 5, 1927; M.D., Northwestern University Medical School, Chicago, Ill., 1953; interned St. Joseph Hospital, Memphis, Tenn., one year; died Jan. 5, 1975, age 47.

STATON, DANIEL E., Columbus. Born Swan Lake, Miss., June 3, 1886; M.D., Tulane University School of Medicine, New Orleans, La., 1909; interned EENT Hospital, New Orleans, La., one year; Emeritus Member of MSMA and AMA; member of Fifty Year Club of MSMA; died Dec. 29, 1974, age 88.

THE PRESIDENT SPEAKING

(Continued)

Continuing medical education is not new to the medical profession. The dedicated physician interested in quality care for his patients has for many years availed himself of a part of the voluminous supply of scientific knowledge offered in various postgraduate courses. Only now, all members of the medical profession must assume the responsibility to deliver quality care, the credibility of which can best be documented by earnest efforts toward continuing medical education. ★★★

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

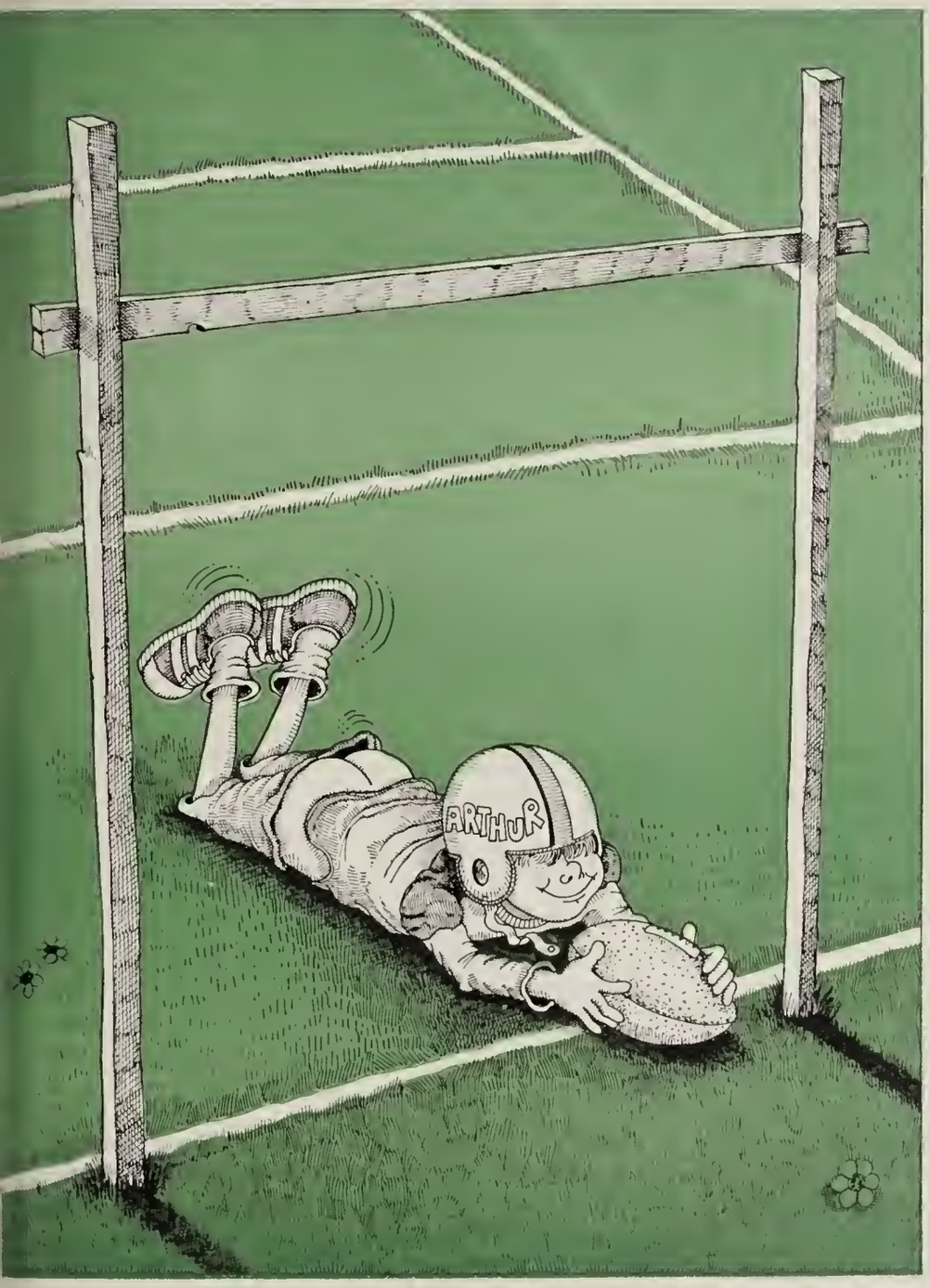
Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

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A division of Pfizer Pharmaceuticals
New York, New York 10017

Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

NEW MEMBERS

Bess, Lloyd George, Greenville. Born St. Louis, Mo., April 5, 1941; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1968; interned Maricupa County General Hospital, Phoenix, Arizona, one year; radiology residency, University of Arkansas, Little Rock, Ark., 1971-74; elected by Delta Medical Society.

Blackwood, Donald James, Cleveland. Born Drew, Miss., Aug. 10, 1946; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1971; interned Parkland Memorial Hospital, Dallas, Tex.; elected by Delta Medical Society.

Bobo, William Owen, Jackson. Born Lambert, Miss., March 29, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1967; interned University of Virginia, Charlottesville, Va., one year; general surgery residency, same, 1968-72; plastic surgery residency, University of Tennessee, Memphis, Tenn., 1972-74; elected by Central Medical Society.

Bordelon, Fred Calvin, Greenville. Born Greenville, Miss., Sept. 16, 1940; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1966; interned, same, one year; otolaryngology residency, same, 1970-73; otolaryngology residency, V.A. Hospital, Memphis, Tenn., 1969-70; elected by Delta Medical Society.

Boyd, Arthur M., Sardis. Born Kingsport, Tenn., June 11, 1947; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1972; interned Baptist Memorial Hospital, Memphis, Tenn., one year; general surgery residency, same, one year; elected by North Mississippi Medical Society.

Bryant, W. Michael, Jackson. Born National City, Calif., Feb. 8, 1938; M.D., Johns Hopkins University School of Medicine, Baltimore, Md., 1963; interned University of Michigan Hospitals, Ann Arbor, Mich., one year; surgery residency, University of Kentucky, Lexington, Ky., 1964-68; plastic surgery residency, same, 1970-71; elected by Central Medical Society.

Burroughs, Judy Faye, Vicksburg. Born Knoxville, Tenn., Jan. 19, 1944; M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1970; interned, same, one year; pathology residency, same, 1971-72; pathology residency, Medical College of Virginia, Richmond, Va., 1972-73; pathology residency, Vanderbilt University, Nashville, 1973-74; elected by West Mississippi Medical Society.

Cabell, Thomas Hargrove, Jackson. Born Jackson, Miss., Nov. 11, 1947; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1973; interned Roanoke Memorial Hospital, Roanoke, Va., one year; elected by Central Medical Society.

Couey, Ira Lamar, Oxford. Born Atlanta, Ga., Aug. 28, 1939; M.D., Medical College of Georgia, Augusta, Ga., 1965; interned Keesler AFB Hospital, Biloxi, Miss., 1965-66; ob-gyn residency, University of Kansas Medical Center, Kansas City, Kan., 1968-72; elected by North Mississippi Medical Society.

Durst, Edward Frank, Greenville. Born Augusta, Ga., Feb. 7, 1942; M.D., Medical College of Georgia, Augusta, Ga., 1967; interned University of Tennessee, Memphis, one year; surgery residency, same, 1968-72; elected by Delta Medical Society.

McCraney, Ward Thomas, Jackson. Born Newton, Miss., Aug. 27, 1941; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1966; interned US Naval Hospital, Portsmouth, Va., one year; orthopaedic surgery residency, Georgia Baptist Hospital, Atlanta, and Scottish Rite Hospital for Crippled Children, Decatur, Ga., 1970-74; elected by Central Medical Society.

Overby, James Allen, Jackson. Born Bruce, Miss., Dec. 23, 1933; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1962; interned Mississippi Baptist Hospital, Jackson, Miss., one year; radiology residency, University of Arkansas, Little Rock, 1970-72; radiology residency, Charity Hospital, New Orleans, La., 1972-73; elected by Central Medical Society.

Parker, John H., Jr., Columbus. Born Jackson, Miss., June 14, 1927; M.D., University of Tennessee College of Medicine, Memphis, 1969; pathology residency, City of Memphis Hospitals, Memphis, 1970-73; elected by Prairie Medical Society.

Pineda, Mario R., Jackson. Born in Argentina, Jan. 9, 1937; M.D., Universidad de Cordola, Argentina, 1961; interned St. Mary's Hospital, West Palm Beach, Fla., one year; psychiatry residency, University Medical Center, Jackson, Miss., 1967-71; elected by Central Medical Society.

Smith, Beverly Ann B., Jackson. Born Bristol, Va., Aug. 22, 1942; M.D., University of Tennessee

College of Medicine, Memphis, 1966; interned Baptist Memorial Hospital, Memphis, Tenn. one year; ob-gyn residency, Mayo Clinic, Rochester, Minn., 1968-70; ob-gyn residency, Bethesda Hospital, Cincinnati, Ohio, 1970-71; elected by Central Medical Society.

VALENZUELA, RAUL E., Jackson. Born Linares, Chile, Oct. 2, 1923; M.D., Facultad de Medicina de la Universidad Catolica de Chile, Santiago, 1951; M.D., same, one year; one year residency, same; ophthalmology residency, San Francisco Deborja Hospital, Santiago, Chile, 1952-53; Wilmer Ophthalmological Institute, Baltimore, Md., 1958-60; elected by Central Medical Society.

WARREN, RICHARD BRADY, JR., Jackson. Born Laurel, Miss., Oct. 20, 1943; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1970; interned, same, one year; medicine residency, same, 1971-74; elected by Central Medical Society.

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

March 12-14, 1975

TREATMENT OF PROBLEMS IN THE NEWBORN

University Medical Center, Jackson
March 12-14, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education and the Department of Pediatrics, Division of Newborn Medicine with support from the Mississippi Regional Medical Program and the Public Health Service, Department of Health, Education, and Welfare

Coordinator:
John E. Rawson, M.D., assistant professor of pediatrics and director of the Newborn Center

The curriculum will focus on normal adaptation, identification of abnormal condition, and management of the sick newborn.

March 13-15, 1975

SURGERY FORUM

The Jackson Hilton Hotel
March 13-15, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education and the School of Medicine Department of Surgery

Coordinators:
James D. Hardy, M.D., professor of surgery and chairman of the department, the University of Mississippi School of Medicine
William O. Barnett, M.D., professor of surgery, the University of Mississippi School of Medicine

This second annual three-day surgery conference features latest advances in surgical procedures. Lectures will cover gastrointestinal, endocrine, colon, pancreas, and breast surgery. Attendance is by invitation, and advance registration with fee of $150.00 is required.

March 20-22, 1975

NEUROLOGY-NEUROSURGERY INTENSIVE COURSE

University Medical Center, Jackson
March 20-22, 1975.

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinators:
Robert D. Currier, M.D., professor of medicine (neurology) and chief of the Division of Neurology, the University of Mississippi School of Medicine
Glen C. Warren, M.D., assistant professor of neurosurgery, the University of Mississippi School of Medicine

This two-day course will be didactic in format with opportunities for the participants to discuss the problems primary care physicians most often encounter. Head injury, the dizzy patient, headaches, epilepsy, sciatica, strokes, and tumors will be discussed in relation to adult and pediatric neurology and neurosurgery.

March 24-28, 1975

CARDIOLOGY INTENSIVE COURSE

University Medical Center
March 24-28, 1975

Sponsored by the University of Mississippi



Effective relief of low back discomfort

The addition of Soma 350 (carisoprodol) to bed rest, moist heat and exercise can help restore range of motion by relieving discomfort associated with acute, painful musculo-skeletal conditions.

Economically...with only one tablet *q.i.d.*

Measure the results yourself. (Wallace will even send you a complimentary goniometer.)

Indications: Carisoprodol is indicated as an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculo-skeletal conditions.
Contraindications: Acute intermittent porphyria and allergic or idiosyncratic reactions to carisoprodol or related compounds such as meprobamate, mebutamate, tybamate.
Warnings: *Idiosyncratic Reactions:* Rarely, extreme weakness, transient quadriplegia, dizziness, ataxia, temporary vision loss, diplopia, mydriasis, dysarthria, agitation, euphoria, confusion and disorientation have appeared within minutes or hours of the first dose. These usually subside in several hours but supportive and symptomatic therapy, including hospitalization, may be necessary.

Pregnancy and Lactation: Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers (concentrations in breast milk are two to four times that in plasma), or women of childbearing potential.

Children Under Twelve: Not recommended.

Potentially Hazardous Tasks: Driving a motor vehicle or operating machinery.

Additive Effects: Effects of carisoprodol and alcohol, other CNS depressants or psychotropic drugs may be additive.

Drug Dependence: Use cautiously in addiction-prone patients.
Precautions: To avoid excess accumulation, use caution in patients with compromised liver or kidney function.
Adverse Reactions: *Central Nervous System:* Drowsiness, dizziness, vertigo, ataxia, tremor, agitation, irritability, headache, depressive reactions, syncope, insomnia, idiosyncratic reaction (see "Warnings").

Allergic or Idiosyncratic: In previously unexposed patients, these are usually seen after 1-4 doses and include rash, erythema multiforme, pruritus, eosinophilia, fixed drug eruption with cross reaction to meprobamate. Asthmatic episodes, fever, weakness, dizziness, angioneurotic edema, smarting eyes, hypotension and anaphylactoid shock may be manifestations of severe reactions. In such cases, stop carisoprodol and initiate appropriate treatment (e.g., epinephrine, antihistamines, corticosteroids).

Cardiovascular: Tachycardia, postural hypotension, facial flushing.

Gastrointestinal: Nausea, vomiting, hiccup, epigastric distress.

Hematologic: Leukopenia and pancytopenia (on carisoprodol plus other drugs).
Usual Adult Dosage: One 350 mg tablet three times daily and at bedtime.
Overdosage: Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. The effects of an overdosage of carisoprodol and alcohol or other CNS depressants or psychotropic agents can be additive even when one of the drugs has been taken in the usual recommended dosage. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisoprodol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

Before prescribing, consult package circular or latest PDR information.

Rev. 8/74

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(carisoprodol) 350 mg tablets

Book Reviews

Two Hundred Years of Pharmacy in Mississippi. By Leslie Caine Campbell. Jackson, Miss.: University Press of Mississippi, 1974. Clothbound $10.00.

Dr. Campbell traces the history of the Mississippi State Pharmaceutical Association from its organization to the present—using the "Proceedings" for most of his material. Of interest to physicians is the fact that in 1871 the Mississippi Medical Association resolved "that the druggist, pharmacists, and chemists of the state of Mississippi be requested to call a convention at an early date, and organize a State Pharmaceutical Association to meet annually at the same time and place that the Medical Association does, and cooperate with it in any and all measures of mutual interest and importance."

On May 29, 1871, in Jackson, Mississippi, the organizational meeting of Mississippi's first State Pharmacy Association took place.

The book reviews the development of the University of Mississippi's School of Pharmacy into one of the nation's leading educational and research centers for the pharmacy profession.

One of the book's most interesting features is the history of the classification and utilization of botanical drugs native to Mississippi. It traces these efforts from Lincecum to Phares to Barkley to Hartman and Doorenbos. It is a shame that more has not been done in this field and it is the hope of this reviewer that the work of the late Dr. Chalres Hartman in promoting a botanical drug industry in Mississippi will continue.

This book is a worthwhile contribution to a special segment of Mississippi history.

Joseph B. Rogers, M.D.
Oxford, Miss.

Handbook of Obstetrics and Gynecology. By Ralph C. Benson, M.D. 770 pages with illustrations. Lange Medical Publications, Los Altos: 1974. $8.00.

This handbook is being constantly improved and has become a worthy companion to two other standard handbooks published by the same publisher, namely, the *Handbook of Medicine* and the *Handbook of Pediatrics.*

Before evaluating the *Handbook of Obstetrics and Gynecology,* the author's preface should be carefully read. This handbook attempts to provide for "the practicing physician and medical student a concise, current, and readily available digest of material for the accurate diagnosis and successful management of obstetric and gynecologic problems." In addition it is aimed at the "nurse, the nurse practitioner, the midwife, and paramedical worker."

In general the objectives outlined above are well met. It is an excellent and quick reference for almost any medical or paramedical personnel except those physicians who are experienced in obstetrics and gynecology and engage in it on a daily basis. For the latter group the standard texts and specialty references are far more suitable.

Since this handbook is aimed at students, nurses, et al, considerably more concisenss could be attained by condensing discussions of such rare entities as arrhenoblastoma (two full pages), oophoritis (two pages), sarcoma of the uterus (three pages), to cite a few. The details of surgical correction of various ureteral fistulae are not warranted in a handbook, nor the techniques for correction of an incompetent cervix.

The most glaring omission is the lack of a discussion of fetal monitoring, and this is a function which will largely be carried out by students, nurses, and nurse practitioners.

The easily read print, the excellent illustrations, the comprehensive index, and the author's obvious concern for the "art of medicine" (witness, for example, his concern for the psychosomatic problems in obstetrics and gynecology and management of the terminal cancer patient) make this a particularly valuable reference for students, nurses, nurse practitioners and paramedical personnel involved in the care of women.

William E. Godfrey, II, M.D.
Natchez, Miss.

PERSONALS

A. M. Adams, Jr., of Senatobia has been named to the Board of Directors of the Panola County Federal Savings and Loan Association. John R. Lovelace of Batesville was re-elected to a three-year term.

J. W. Austin of Forest is new president of Central Medical Society. Ellis Moffitt of Jackson is secretary and Max Pharr of Jackson is president-elect.

William Knox Austin, Jr., formerly of Madison, and William H. Meyer of Jackson have joined the staff of Southwest Regional Medical Center in McComb. Dr. Austin specializes in ENT and Dr. Meyer in orthopedic surgery.

Ralph Bell has associated with Robert Mitchell for general practice at 3206 10th Street in Gulfport.

Hackett Bennett has returned to his general and surgical practice at 5th Floor, 505 Greater Mississippi Life Building in Meridian.

Dewitt L. Bolton, formerly of Picayune, has joined the Family Clinic in Brookhaven and will be associated with Jim Barnett.

Donald J. Booth announces the opening of his office for the practice of surgery at 1210 W. Division Street in Biloxi.

New officers of Northeast Mississippi Medical Society are president, Eugene V. Bramlett of Batesville; secretary, Lee H. Rogers of Tupelo; and president-elect, John M. Patterson of Pontotoc.

New officers of Prairie Medical Society are president, L. H. Brandon, Jr., of Starkville; secretary, G. O. Spencer, Jr., of Columbus; and president-elect, W. C. Gates of Columbus.

John W. Byarly of Corinth has been nominated for "Outstanding Young Man of the Year" by the Corinth Jaycees.

Isaac Cooper East of Brandon was honored on his retirement from medical practice with a buffet luncheon on New Year's Day at the home of his daughter in Forest.

W. Raymond Fannin, Jr., has associated with Clinical Psychology Associates for the practice of child and adolescent psychiatry at Suite 234, Highland Village, 4500 Interstate 55 North in Jackson.

Thomas Gandy of Natchez was appointed to a three-year term on the Board of Trustees at Jefferson Davis Memorial Hospital. He replaces Sidney Graves of Natchez whose term expired.

John Gassaway has associated with the Medical Arts Clinic in Starkville for the practice of bone and joint surgery.

James D. Hardy of Jackson and UMC was in Charlottesville, Va., in January for the American Surgical Association presidents' dinner.

J. W. Holmes of Wiggins has been named president-elect of the Coast Counties Medical Society.

Myron W. Lockey of Jackson and UMC presented a paper at the Southern Section, American Triological Society meeting in Tampa.

Eugene McCarty is now the fulltime physician at the Voice of Calvary Cooperative Health Center, 309 Center Street in Mendenhall.

Ray F. Motley of Laurel has been named to "Who's Who in Mississippi, 1974." Dr. Motley, a pathologist, is director of the laboratory at Jones County Community Hospital.

Howard Nelson of Greenwood has been serving as chairman of the Committee on Health and Sanitation of the Greenwood-Leflore County Chamber of Commerce.

Bernard S. Patrick of Jackson and UMC participated in a *Surgical Neurology Journal* meeting in Greenville, S. C.

W. J. Patterson announces the association of Glenn F. Morris with the Clinton Family Clinic at 650 Highway 80 East in Clinton.

James W. Pressler of McComb announces the removal of his office to 421 Marion Drive.

Thomas A. Randle of Oxford will serve as Heart Fund Chairman of District 5 for the 1975 campaign.

William Thomas Robinson of Clarksdale announces the relocation of his surgical office to Medical Arts Building, 645 Evelyn Drive.

G. Boyd Shaw of Jackson has been named president of the medical staff for 1975 at Mississippi Baptist Hospital. He succeeds James O. Manning.

Ellis M. Moffitt is the new president-elect and L. R. Hodges is secretary. Sectional chiefs and assistants, respectively, are: L. R. Hodges and W. D. Godfrey, surgery; R. E. Tyson and L. H. Fulcher, medicine; R. H. Thompson and W. F. Sistrunk, pediatrics; Thomas E. Holden and Lewis D. Lipscomb, ob-gyn; Max L. Pharr and H. B. Woodbridge, family practice; and A. J. Santangelo, psychiatry.

Omar Simmons of Newton has been listed in "Who's Who in Mississippi, 1974."

Beverly Ann Smith announces the opening of her offices for the practice of obstetrics and gynecology at the Medical Arts Building, Suite 608, 1151 North State Street in Jackson.

Robert E. Tyson of Jackson was elected chairman of the Medical and Scientific Committee of the Mississippi Chapter of the Arthritis Foundation. Thomas E. Stevens of Jackson was named treasurer.

Joe W. Walker of Water Valley was elected chief of staff at Yalobusha County General Hospital. Others on the staff are: D. E. Spears and M. S. McMillan of Water Valley; Ralph Criss of Coffeeville; and C. M. Jordan of Grenada.

W. L. Weems of Jackson and UMC was visiting professor to the LSU Medical Center Department of Urology at Shreveport.

History of Medicine Society Meets

The History of Medicine Society met on Thursday, Feb. 6, at the Medical Alumni House in Jackson.

Guest speaker was Dr. David Pankratz, dean emeritus of the University of Mississippi School of Medicine. Dr. Pankratz, who is currently writing a book on the history of the Mississippi medical school, spoke on distinguished physicians in the history of Mississippi medicine.

Members are reminded to submit $10 annual dues to the secretary-treasurer, Dr. J. W. Laing, Department of Neurosurgery, UMC, 2500 North State Street, Jackson, MS 39216.

Mrs. Dees Is SMA Auxiliary President-elect

Mrs. Opal Dees of Jackson has been elected president-elect of the Southern Medical Association Woman's Auxiliary.



Mrs. Dees

Mrs. Dees is a member of the Central Medical Auxiliary and Woman's Auxiliary to MSMA. She has served as president of Central and she chaired the auxiliary's participation in Health Expo I. Mrs. Dees was the first editor of "Distaff" and served in that capacity for four years.

On a national level, she was chairman of International Health for the Southern District.

As a member of Southern Medical Auxiliary, she has worked on the Committee of Research and Romance of Medicine, served as chairman of the Auditing Committee, and was first vice president during 1974.

Mrs. Dees is married to Dr. J. Gordon Dees, a general surgeon, and they are the parents of four children. Mrs. Dees is a graduate of Jonesboro A & M and received her R.N. from the University of Tennessee in Memphis.

Other community involvements of this physician's wife include PTA president, Board member of the Jackson Symphony League, Board member of the Willard Bond Home for indigent senior citizens, and Girl Scout leader.

In 1966 Mrs. Dees was selected as Mississippi's Mother of the Year.

Medical Audit Seminar Set for Biloxi

The Joint Commission on Accreditation of Hospitals (JCAH) will present a MATS-Medical Audit Team Seminar at the Sheraton Motor Inn in Biloxi, March 25-26, 1975.

The program is sponsored by the Mississippi Hospital Association with cosponsorship by MSMA and

the Mississippi Medical Record Association.

The MATS present intensive training in the JCAH's Performance Evaluation Procedure for Auditing and Improving Patient Care (PEP). Simulated audit exercises, lectures, and demonstrations are used to teach the participants each step of the audit procedure.

MATS are intended for physicians and medical record personnel. The registration fee is $125.00 per participant and covers all materials and luncheons.

The program is approved for credit toward the AMA's Physician Recognition Award, Category I.

Registration and checks should be mailed to: Charles W. Flynn, Mississippi Hospital Association, P. O. Box 16444, Jackson, MS 39206.

Malpractice Legislation Is Top Issue

Medical malpractice legislation has become a top issue before the 94th Congress. Three major bills have been introduced and Senator Edward Kennedy's Subcommittee on Health plans to begin hearings on proposed legislation in mid-March.

Senator Gaylord Nelson (D-Wis.) has introduced S 188 which would establish within the Department of HEW a "National Medical Malpractice Development Fund" similar to existing federal flood reinsurance programs. The proposal would protect primary insurance companies against catastrophic malpractice claims losses by providing a reinsurance pool to pay liability claims above $25,000.

Another proposal cosponsored by Senators Daniel Inouye (D-Hawaii) and Kennedy would establish a federal system of compensation patterned after the present Workman's Compensation Program. The program which would be voluntary would require physicians to comply with standards of licensure and relicensure established by the Secretary of HEW. In addition, physicians participating in the program would have to agree to accept review of their services by PSROs, to accept Medicare assignments, and to obtain concurring opinions from specialists prior to performing surgical procedures.

In the House, Congressman Dan Rostenkowski (D-Ill.), chairman of the Ways and Means Committee's Subcommittee on Health, has introduced HR 1378 which would provide for studies of malpractice insurance problems. The studies would be conducted by the Office of Technology Assessment in cooperation with the National Academy of Sciences.

Two Physicians Appointed to St. Dominic Board

Sister Josephine Therese, Administrator of St. Dominic-Jackson Memorial Hospital, has announced the appointment of two members of the Medical and Dental Staff to the Governing Board of the hospital.

Dr. William E. Bowlus and Dr. William B. Thompson were appointed at the Jan. 14, 1975, meeting of the Governing Board.

In announcing the appointment, Sister said, "The Sisters and laymen on the Board feel that because of the physician's importance to the total operation of the hospital and because of the Board's responsibility for quality of care in the institution, physicians should be included as members of the Board." "As active practitioners," Sister Josephine said, "these physicians can help the Board recognize the important role that medicine plays in a successful health care institution."

"We congratulate these two fine men on their appointment," the administrator said, "and share the Board's confidence that they will represent the medical interest of our community and our staff in the best possible manner."

Dr. Davis Speaks to Woman's Auxiliary



Dr. J. T. Davis of Corinth, MSMA president, was guest speaker before the Winter Board Meeting of the Woman's Auxiliary to MSMA on Jan. 21 in Jackson. Dr. Davis spoke on the past and future of organized medicine.

The 107th Annual Session of MSMA at Biloxi Will Offer Something for Everyone

Outstanding guest speakers for the scientific meeting and numerous business and social occasions have been lined up for the 107th Annual Session of the Mississippi State Medical Association, May 5-8, 1975, at Biloxi. A condensed schedule is planned and the convention will end at noon on Thursday, May 8.



Dr. Spell

Dr. James P. Spell of Jackson, chairman of the Council on Scientific Assembly, made the announcement and stated that the convention will again be held at the Sheraton-Biloxi Hotel.

The annual session opens with the House of Delegates on Monday morning, May 5. Dr. Malcolm C. Todd, AMA president, will be special guest speaker. The House also meets on Thursday morning when MSMA policy will be decided and new officers elected.

The Scientific Assembly opens on Sunday, May 4, with the new Section on Anesthesiology meeting. The other seven sections of the association will meet on Tuesday and Wednesday, May 6 and 7. Scientific presentations will be offered in anesthesiology, surgery, medicine, preventive medicine, family practice, ob-gyn, pediatrics and EENT.

Guest essayists include Drs. Arthur J. Donovan, chairman of surgery at South Alabama Medical School in Mobile; John Collins, associate professor of surgery at Harvard; Daniel M. Hays, professor of surgery at USC School of Medicine; William C. North, professor and chairman of anesthesiology at the University of Tennessee; Theodore M. King, director of gynecology and obstetrics at Johns Hopkins; Alan I. Mandell of the University of Tennessee Department of Ophthalmology; Gale Gardner of Memphis; Howard L. McMartin of HEW; Gene Hunder of the Mayo Clinic; and Jerome R. Ryan of Tulane.

Fourteen specialty groups will have concurrent meetings, and medical alumni from Ole Miss, Tennessee, Tulane and Vanderbilt are scheduling social occasions. The annual association fellowship party is on the Tuesday evening agenda.

A special offering this year will be "Arthritis Day," on Sunday, May 4, sponsored by Mississippi Regional Medical Program and the Mississippi Methodist Rehabilitation Center.

Some 20 scientific exhibits will be offered to convention-goers as well as over 30 technical exhibits by ethical pharmaceutical manufacturers, medical supply houses, etc.

The Woman's Auxiliary is finalizing plans for its concurrent annual session and the president of Southern Medical and an AMA auxiliary director will be special guests.

Other events slated for convention week include the Fifty Year Club, Past President's Breakfast and various related group meetings.

Early registration at the Sheraton is recommended; officials are predicting a sellout by April. The MSMA headquarters office is handling all hotel reservations and advance registration forms have been sent to MSMA members.

The entire annual session program and the House of Delegates handbook will be printed in the April issue of the JOURNAL MSMA.

Psychosomatic Society Plans Meeting

The American Psychosomatic Society will hold its annual meeting in New Orleans, March 21-23. On the 21st, in cooperation with the Tulane and Louisiana State Universities, the society has arranged a Continuing Education Program in Psychosomatic Medicine which includes three panel discussions:

I. Diagnosis and Pharmacologic Treatment of Depressive States with Donald Gallant, John Davis, David Mielke.

II. Psychosocial Aspects of Life-Threatening Illness (Clinical Approach to the Patient; Prolongation of the Patient's Life) with Franz Reichsman, Arthur Schmale and others.

III. Psychosocial Aspects of Coronary Disease (Illness-Onset Situation; Behavior Patterns) with Frederick Guggenheim and others.

Additional information may be obtained from Chase Patterson Kimball, M.D., 950 E. 59th Street Box 411, University of Chicago, Chicago 60637.

M.D.s Get Postgraduate Education at UMC



Physicians who took a week-long intensive refresher course in electrocardiography at the University Medical Center included, front, from left, Dr. Gordon S. McHenry, Wiggins; Dr. W. B. White, Laurel; Dr. Joe J. Bethany, Jr., Eutaw, Ala.; and, back, Dr. Elmo Gabbert, Meadville, and Dr. John M. Alford, Greenwood. Dr. N. E. Murillo Smith of Meridian also participated in the discussions of principles, techniques, and advances in EKG. The course, one of 10 the UMC Division of Continuing Health Professional Education offers this spring, was partially supported by a Mississippi Regional Medical Program grant.

UMC Surgical Forum Is This Month

Surgeons from 37 states will come to Mississippi in March for the three-day University of Mississippi postgraduate surgical forum.

The conference, scheduled March 13, 14, and 15 at the Jackson Hilton Hotel, is sponsored by the UMC Department of Surgery and the Division of Continuing Health Professional Education. Enrollment, limited to 250—a hundred more than last year's number, is filled.

Eleven nationally-known surgeons will discuss advances and techniques in their field. Program planners allow a half-day for gastrointestinal, endocrine, and pancreas and breast surgical procedures, with a full day devoted to colon problems.

Guest speakers include Dr. Isidore Cohn, Louisiana State University School of Medicine, New Orleans; Dr. Theodore Drapanas, Tulane University School of Medicine, New Orleans; Dr. Stanley J. Dudrick, University of Texas Medical School, Houston; Dr. Richard H. Egdahl, Boston University School of Medicine, Boston; and Dr. John M. Howard, Crozer-Chester Medical Center, Upland Chester, Pa.

Other visiting lecturers are Dr. Francis D. Moore, Harvard Medical School, Boston; Dr. H. William Scott, Jr., Vanderbilt University School of Medicine; Dr. Colin G. Thomas, University of North Carolina School of Medicine, Chapel Hill; Dr. R. B. Turnbull, The Clinic Center, Cleveland; Dr. Claude E. Welch, Harvard Medical School, Boston; and Dr. Robert M. Zollinger, The Ohio State University College of Medicine, Columbus.

University Medical Center faculty who are on program include Dr. William O. Barnett, professor of surgery; Dr. D. David Glass, assistant professor of anesthesiology and assistant professor of surgery; Dr. James D. Hardy, professor of surgery and chairman of the department; Dr. J. Harvey Johnston, Jr., clinical professor of surgery; Dr. Richard C. Miller, associate professor of surgery, assistant professor of pediatrics, and associate dean, School of Medicine; Dr. Norman C. Nelson, vice chancellor for health affairs, University Medical Center, dean of the School of Medicine and professor of surgery; Dr. Rush E. Netterville, clinical associate professor of surgery; and Dr. George V. Smith, associate professor of surgery.

Coordinators for the second annual event are Dr. William O. Barnett and Dr. James D. Hardy.

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

APRIL 1975

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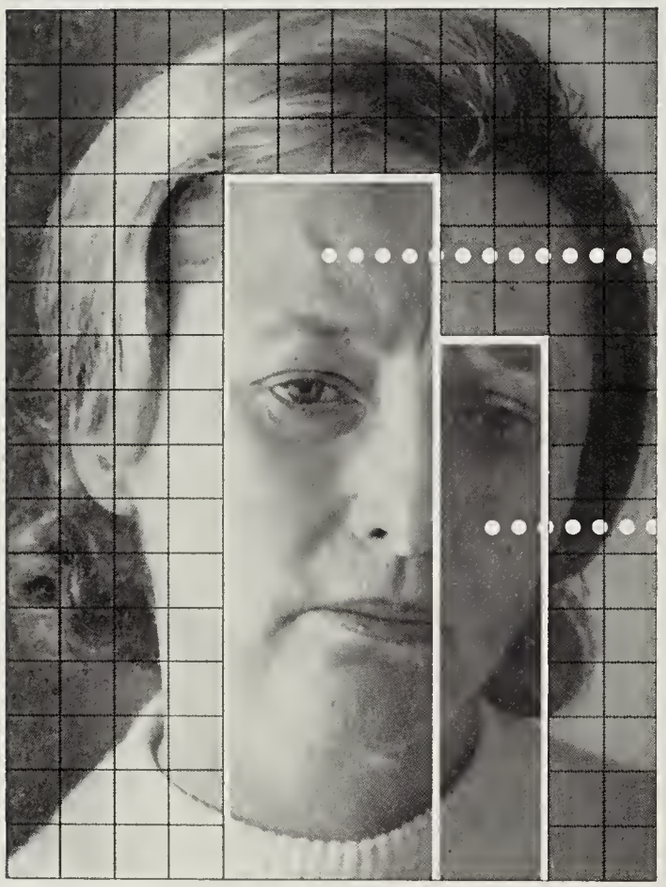
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Fistula, 107th Annual
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Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard ant convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
April 1975, Vol. XVI, No. 4

ORIGINAL PAPERS

Radiologic Seminar CL: Spontaneous Closure of a Renal Arteriovenous Fistula

JAMES TRAPP, M.D., JOHN ELLIOTT, M.D.,
JAMES GORDON, M.D., JOHN EVANS, M.D., and
LUKE PLATT, M.D

An 18-year-old female was first admitted to the North Mississippi Medical Center one week after sustaining multiple injuries in an automobile accident. Hematuria was one of her post-trauma symptoms, and an IVP performed one day after trauma revealed an abnormal appearing left kidney. Upon admission to North Mississippi Medical Center, her blood pressure was 120/80, temperature, 99°, pulse 80. The hemoglobin was 10.5, the white count 5400, hematocrit 32. The urinalysis demonstrated 1+ protein and many red blood cells. The admission chest x-ray was normal. A static renal scan showed a large left parenchyma defect. A Technetium renal flow study demonstrated diminished activity in the left kidney as compared to the right. Angiography revealed two left renal arteries with the upper renal artery supplying a large traumatic arteriovenous fistula. No ischemic changes were demonstrated in the left kidney and there was no evidence of hepatic or splenic injury.

Because of the patient's generally stable condition, it was elected to observe her, hoping for spontaneous closure of this traumatic arteriovenous fistula. She was discharged on limited physical activity on July 5, 1974, and had an uneventful post-hospitalization course. She was re-admitted to the hospital on Aug. 26, 1974, at which time her blood pressure was 106/80, pulse 80, and the temperature normal. The hemoglobin was 10.2, white count 7200, hematocrit 32 and urinalysis showed 3 to 4 red blood cells, but was negative for protein. Repeat renal arteriography was performed, including direct serial magnification of the left renal arteriogram which revealed complete closure of the traumatic arteriovenous fistula previously demonstrated.

Some people have considered traumatic arteriovenous fistulas, involving the renal arteries, as an indication for surgical intervention. Halpern in 1969 reported on 5 cases in his experience which demonstrated spontaneous closure of traumatic arteriovenous fistulas of the renal artery. Lang has advocated the liberal use of renal arteriography in evaluating renal trauma, and he has pointed out the deleterious effects of demonstrated ischemic changes in the kidney following trauma, especially those which exhibit arteriovenous communications. The present case is interesting in that it demonstrates rather prompt closure with conservative management. It would further seem logical to assume that the demonstrated closure of this arteriovenous fistula is permanent.

The present case suggests that conservative management of post-traumatic arteriovenous fistulas of

Sponsored by Mississippi Radiological Society.
From the Departments of Radiology and Urology, North Mississippi Medical Center, Tupelo, Miss.



Figure 1. Left renal arteriogram, demonstrating traumatic arteriovenous fistula from the upper of two left renal arteries.

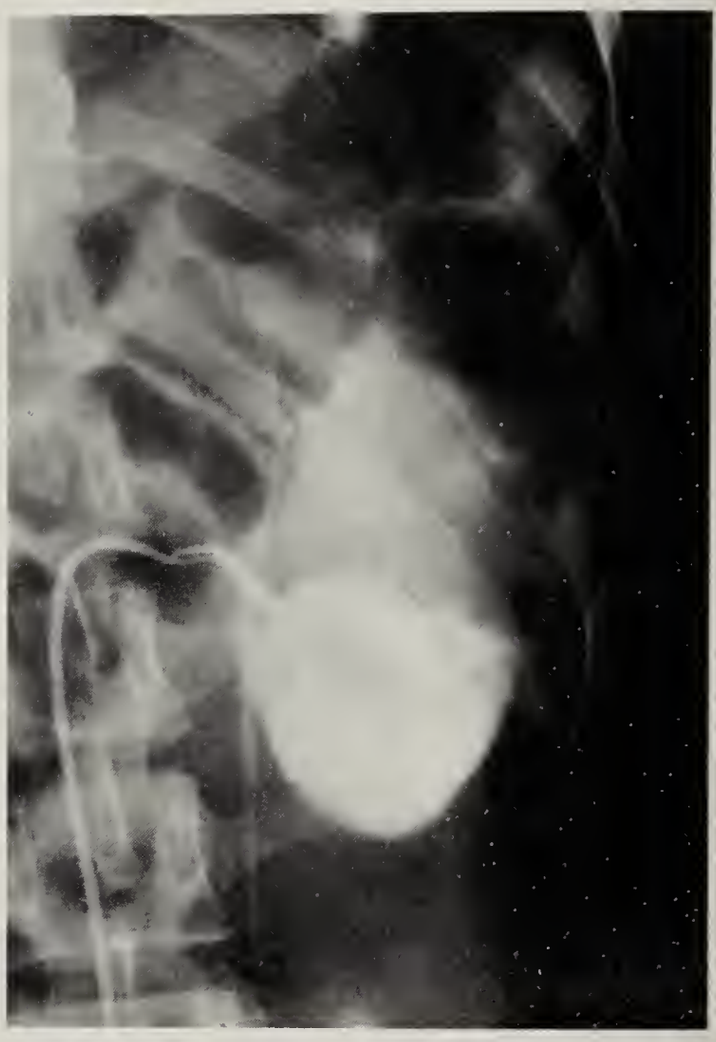


Figure 2. Left renal arteriogram of lower left renal artery, showing no abnormalities.



Figure 3. Follow-up left renal arteriogram seven weeks after first study, showing closure of arteriovenous fistula.



Figure 4. Direct serial magnification of follow-up left renal arteriogram, showing closure of arteriovenous fistula.

the renal artery is not an unthinkable alternative to operative intervention. It would appear that factors of importance are the general hemodynamic stability of the patient and the overall appearance of the kidney at the time of angiography. Ischemic changes in the kidney as well as signs of other associated massive injury or damage to the kidney are angiographic indicators that conservative management may be unwise. The age and pre-trauma condition of the patient as well as the clinical course of the patient while under observation are other factors to be considered in making the decision of how best to manage such a patient.

SUMMARY

A case is presented of an 18-year-old trauma victim who suffered left renal injury resulting in traumatic arteriovenous fistula which subsequently underwent demonstrated spontaneous closure. The patient was successfully managed by conservative observation rather than operative intervention. Her immediate post-trauma course, as well as her course during observation, was one of general physical and hemodynamic stability. Her arteriogram revealed an arteriovenous fistula, but did not demonstrate ischemic changes in the kidney and did not demonstrate evidence of other massive renal trauma. This case suggests that conservative management of such condition may be feasible in selective patients. ★★★

835 Gloster Street (38801)

REFERENCES

1. Halpern, M.: Spontaneous Closure of Traumatic Renal Arteriovenous Fistulas. Am. J. Roentgenol., Rad. Therapy & Nucl. Med. 107:730-736, 1969.
2. Lang, E. K. et al: Renal Arteriography in the Assessment of Renal Trauma. Radiol. 98:103-113, 1971.

A restaurant owner from the Old Country kept his accounts payable in a cigar box on the left side of the cash register, his daily cash returns in the cash register, and his receipts for paid bills in another cigar box on the right.

His accountant son, appalled by the primitive bookkeeping system, remarked: "I don't see how you can run a business that way. How do you know what your profits are?"

"Well, son," the father replied, "When I got off the boat from Greece, I had nothing but the pants I was wearing. Today, your brother is a doctor, your sister is a speech therapist, you're an accountant. Your mother and I have a nice car, a city house, a country home, a good business and everything's paid for. So, add all that together, subtract the pants—and there's your profit."

107th Annual Session

Mississippi State Medical Association
May 5-8, 1975
Biloxi

MISSISSIPPI'S GULF COAST will become the state's medical capital May 5-8 as the 107th Annual Session of the association gets underway at the Sheraton-Biloxi. Eight scientific sections, fifteen specialty and related groups, four medical alumni occasions, technical and scientific exhibits, the House of Delegates, and a host of fellowship events are slated for the four-day meet.

Dr. J. T. Davis of Corinth, association president, will address the opening meeting of the House of Delegates on May 5. House Speaker Walter H. Simmons of Jackson and Vice Speaker C. D. Taylor of Pass Christian said that reports and resolutions will be presented at the opening meeting. Final action will come on May 8 when 1975-76 officers are also elected.

Dr. Jack Atkinson of Brookhaven will be inaugurated president for the new year during closing ceremonies on the final day.

Dr. James P. Spell of Jackson said that the Scientific Assembly will open on Sunday evening, May 4, and continue through Wednesday noon. Wednesday afternoon has been left completely free for convention goers to take advantage of the sun and surf. The Scientific Assembly has been approved for 12 hours of Category I, AMA Physician Recognition Award credit and 12 hours of MAFP prescribed credit. The program was prepared with the cooperation of the Section on Family Practice. Dr. Spell heads the group which has planned and scheduled the general and specialty sessions, exhibits and fellowship occasions.

Principal speaker for the annual session is Dr. Malcolm C. Todd of Long Beach, Calif., president of the American Medical Association. He is scheduled to address the opening meeting of the House of Delegates on May 5, Dr. Davis said.

The Woman's Auxiliary will conduct its 52nd Annual Session concurrently during May 5-7, also headquartering at the Sheraton-Biloxi, according to Mrs. Dan Reikes of Hattiesburg, state president. Mrs. Edward Hill of Hollandale will be inaugurated 1975-76 president of the auxiliary at the meeting. General chairwomen for the ladies' meet are Mrs. T. Erskine Ross, III, of Hattiesburg and Mrs. A. T. Tatum of Petal.

Medical alumni occasions are set for Monday evening and events are scheduled by Ole Miss, Tennessee, Tulane and Vanderbilt. The annual association fellowship party is the special Tuesday evening feature.

Reservations at the Sheraton-Biloxi are being made through the MSMA office in Jackson; if additional rooms are needed, reservations will be made at the nearby Ramada Inn and Holiday Inn.

OFFICIAL CALL

To all members of the Mississippi
State Medical Association:

The 107th Annual Session of the Mississippi State Medical Association is called to meet at Biloxi, Mississippi, on Monday, May 5, 1975, pursuant to Article V of the Constitution. The House of Delegates will be convened at 9 o'clock in the morning at the Sheraton-Biloxi on May 5.

The Scientific Assembly, consisting of the eight general sessions, will meet during May 4-7, 1975.

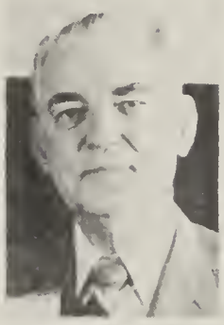
No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

J. T. DAVIS
PRESIDENT
JAMES P. SPELL
SECRETARY-TREASURER

STATE OFFICERS 1974-1975



Dr. Davis



Dr. Atkinson

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J. T. Davis
Corinth

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C. P. Crenshaw, Collins	1962-63
Omar Simmons, Newton	1964-65
Everett Crawford, Tylertown	1965-66
James T. Thompson, Moss Point	1966-67
Temple Ainsworth, Jackson	1967-68
Joseph B. Rogers, Oxford	1968-69
James L. Royals, Jackson	1969-70
Paul B. Brumby, Lexington	1970-71
Charles R. Jenkins, Laurel	1972-73
Arthur A. Derrick, Jr., Durant	1973-74

ACTIVITIES CALENDAR

REGISTRATION

General Registration for the Scientific Assembly and House of Delegates will be located at the second level (Grand Ballroom and Gulf Rooms) in the Sheraton-Biloxi. No person may be admitted to any activity of the annual session without first registering. Hours of registration will be 2:00 to 4:00 p.m., Sunday, May 4; 8:00 a.m. to 5:00 p.m., Monday, Tuesday and Wednesday, May 5, 6, and 7; and 8:00 a.m. to 9:00 a.m., Thursday, May 8. The Secretary's office will be located off the arcade on the first level.

107TH ANNUAL SESSION

SUNDAY, MAY 4, 1975

9:00 a.m. Miss. Dermatological Society Business Meeting, Gulf Room A
12:00 noon Miss. Psychiatric Association Luncheon and Scientific Session, Gulf Room B
2:00 p.m. Miss. Association of Pathologists Business Meeting, Biloxi Room
2:00 p.m. Auxiliary Hospitality Area and Registration, First Floor Lobby
2:00 p.m. MSMA Registration, Second Level Lobby
2:00 p.m. Arthritis Day Seminar, Gulf Room C
6:30 p.m. Miss. Society of Anesthesiologists Dinner and Scientific Section Program, Grand Ballroom

MONDAY, MAY 5, 1975

7:00 a.m. Reference Committee Breakfast, Gulf Room D
9:00 a.m. House of Delegates, Top of the Sheraton
9:30 a.m. Miss. Sports Medicine Society Organizational Meeting, Gulf Room C
10:30 a.m. Woman's Auxiliary Finance Committee Meeting, Gulf Room B
11:00 a.m. Miss. Orthopaedic Society Scientific Session and Luncheon, Gulf Room D
11:00 a.m. Miss. Neurosurgical Society Program and Luncheon, Boston Room
12:00 noon Miss. Urological Society Luncheon, Gulf Room C
1:30 p.m. Reference Committee on Reports of Officers and Board of Trustees, Gulf Room A
2:00 p.m. Miss. Commission on Hospital Care Meeting, Biloxi Room
3:00 p.m. Reference Committee on Medical Practices, Gulf Room D
3:00 p.m. Woman's Auxiliary Preconvention Board Meeting, Boston Room
3:30 p.m. Council on Constitution and By-Laws, Gulf Room C
4:00 p.m. Tonometry Course, Gulf Room B
4:00 p.m. Ole Miss Medical Alumni Business Meeting, Jackson Room
6:00 p.m. Tulane Medical Alumni Reception, Empire Room
6:00 p.m. Vanderbilt Medical Alumni Reception, Jackson Room
6:00 p.m. Tennessee Medical Alumni Reception, Gulf Room A
7:00 p.m. Ole Miss Medical Alumni Seafood Jamboree, Top of the Sheraton

TUESDAY, MAY 6, 1975

7:30 a.m. American College of Surgeons Officers Breakfast, Boston Room
8:00 a.m. Woman's Auxiliary Continental Breakfast, Grand Ballroom
9:30 a.m. Woman's Auxiliary General Session, Grand Ballroom
9:00 a.m. American College of Surgeons Scientific Meeting, Gulf Room C
9:00 a.m. MSMA Section on Family Practice, Gulf Room A
9:00 a.m. MSMA Section on EENT, Empire Room
12:00 noon Mississippi Academy of Family Physicians Luncheon, Gulf Rooms A and B
12:00 noon American College of Surgeons Luncheon, Gulf Rooms C and D
12:00 noon Miss. EENT Association Luncheon, Biloxi Room
12:00 noon Fifty Year Club Luncheon, Boston Room
1:00 p.m. Woman's Auxiliary Luncheon, Top of the Sheraton
1:30 p.m. MSMA Section on Preventive Medicine, Empire Room
1:30 p.m. MSMA Section on Surgery, Gulf Room C
3:00 p.m. Tonometry Course, Gulf Room B
3:30 p.m. Woman's Auxiliary Postconvention Board Meeting, Jackson Room

WEDNESDAY, MAY 7, 1975

7:30 a.m. MSMA Past Presidents' Breakfast, Boston Room
9:00 a.m. MSMA Section on Ob-Gyn, Gulf Room B
9:00 a.m. MSMA Section on Pediatrics, Gulf Room C
9:00 a.m. MSMA Section on Medicine, Gulf Room D
9:00 a.m. Woman's Auxiliary Past Presidents' Breakfast, Biloxi Room
10:00 a.m. Woman's Auxiliary Workshop, Jackson Room
11:00 a.m. MSMA Nominating Committee, Gulf Room A
12:00 noon Miss. Ob-Gyn Society Luncheon, Boston Room
12:00 noon Miss. Society of Internal Medicine Luncheon, Empire Room

7:00 p.m. MSMA Fellowship Party, Gulf Rooms

THURSDAY, MAY 8, 1975

9:00 a.m. House of Delegates, Top of the Sheraton

EXECUTIVE BUSINESS



DR. SIMMONS

Walter H. Simmons
Jackson, Speaker



DR. TAYLOR

C. D. Taylor, Jr.
Pass Christian,
Vice Speaker



DR. TODD

HOUSE OF DELEGATES
May 5, 1975, 9:00 a.m.
Sheraton-Biloxi

MEETINGS OF THE HOUSE OF DELEGATES

The opening meeting of the House will be called to order by the President, and the Speakers will announce the order of business. An open meeting on May 5, to which all members and ladies of the Auxiliary are invited, will feature addresses by Dr. J. T. Davis, the president, and Dr. Malcolm Todd, president of the American Medical Association. The adjourned meeting of the House will convene at 9:00 a.m. on May 8.

REFERENCE COMMITTEES

Reports of Officers and Board of Trustees, May 5, Gulf Room A, 1:30 p.m.

Medical Practices, May 5, Gulf Room D, 3:00 p.m.

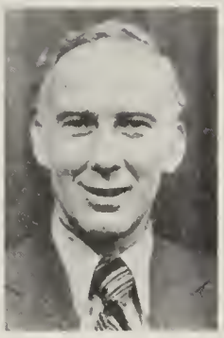
Constitution and By-Laws, May 5, Gulf Room C, 3:30 p.m.

Nominating Committee, May 7, Gulf Room A, 11:00 a.m.

THE SCIENTIFIC ASSEMBLY

COUNCIL ON SCIENTIFIC ASSEMBLY

JAMES P. SPELL, Chairman



DR. SPELL

THE COUNCIL

CARLOS S. PATINO, Chairman, Anesthesiology
KATHERINE A. ALDRIDGE, Secretary

LARRY H. DAY, Chairman, EENT
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CHARLTON R. VINCENT, Secretary

RICHARD C. MILLER, Chairman, Pediatrics
ROBERT L. ABNEY, III, Secretary

THOMAS E. WALLER, Chairman, Preventive Medicine
STEVEN L. MOORE, Secretary

T. ERSKINE ROSS, III, Chairman, Surgery
HENRY B. TYLER, Secretary

SCIENTIFIC AND TECHNICAL EXHIBITS

Grand Ballroom, Sheraton-Biloxi

THE SCIENTIFIC EXHIBIT

Physicians, foundations, organizations, and major medical institutions will present the Scientific Exhibit. Physician-members of the Mississippi State Medical Association are eligible for the Aesculapius Award given for excellence of presentation, quality of content, and originality. Others may not participate in this competition, but they are eligible for the association's Scientific Achievement Award, a sculptured bronze medallion, in recognition of the best presentation by a nonmember. The Scientific Exhibit is located in the Grand Ballroom.

EXHIBITS AND AUTHORS

"Transplantation of the Kidney"
George V. Smith, Department of Surgery, University Medical Center, Jackson

"Chain Saw vs. Face: Another Hazard of Mechanical Progress"
W. Michael Bryant and Michael E. Jabaley, Division of Plastic Surgery, University Medical Center, Jackson

"Cancer Education Service: Dial Access System"
Southern Medical Association, Birmingham

"United Ostomy Association Exhibit"
Gulf Coast Ostomy Association, Ocean Springs

"Portal Hypertension"
S. Raju, James D. Hardy and W. T. Rueff, Department of Surgery, University Medical Center, Jackson

"Mississippi Crippled Children's Treatment Center"
John G. Caden, Jackson

"Coronary Artery Disease—Surgical Treatment"
Charles W. Pearce, White E. Gibson, III, and Rudolph Weichert, III, New Orleans

"Nonoperative Closure of Left-to-Right Shunt"
Terry King, and Noel Mills, New Orleans

"Prevent Blindness"
Mississippi Society for the Prevention of Blindness, Inc.

"Arthritis and Rehabilitation Communications"
George W. Wharton, Guy T. Vise, Jr., and William C. Norris, Jackson

"The Cancer Nobody Talks About"
American Cancer Society, Mississippi Division, Inc.

"Home Health Program"
Mississippi State Board of Health

"Abdominal and Obstetrical Ultrasonography"
Kenneth G. Carter and James M. Packer, Jackson

"Pediatric Malignancies"
Richard C. Miller, Jeanette Pullen, and Patricia C. Moynihan, Departments of Surgery and Pediatrics, University Medical Center, Jackson

"You—Your Patient—Your Heart Association"
Mississippi Heart Association

"Diagnosis of Coronary Artery Disease"
H. Davis Dear, Jr., and McKamy Smith, Jackson

"Muscle Flaps in Reconstructive Surgery"
Heber C. Ethridge, W. Douglas Godfrey, and William O. Bobo, Jackson

"Combined Surgery and Chemotherapy for Cancer of the Breast and Digestive Tract"
Edward M. Lowicki, Jack B. Campbell and Charles E. Farmer, Jackson

"Results of Cardiac Surgery at the Mississippi Baptist Hospital"
Thomas L. Kilgore and Martin McMullan, Jackson

"Overview of Parent Effectiveness Training"
Human Effectiveness Institute

THE TECHNICAL EXHIBIT

The Mississippi State Medical Association presents with pride the 1975 Technical Exhibit. Established firms engaged in the manufacture and distribution of pharmaceuticals, supplies, or equipment, and in providing varied services, will present the exhibits. Visit each exhibit often and discuss products and services with the Professional Service Representatives. Only registered members and guests are admitted. The Technical Exhibit is located in the Grand Ballroom.

EXHIBITORS	BOOTH
General Medical, Jackson, Miss.	1
Bedsole Surgical Supply Co., Inc., Mobile, Ala	2
Lanier Business Products, Jackson, Miss.	3
Blue Cross & Blue Shield of Miss., Inc., Jackson, Miss.	4
First Investment Company, Jackson, Miss.	5
Hill Crest Hospital, Birmingham, Ala.	6
Stuart Pharmaceuticals, Wilmington, Del.	7
St. Paul Fire & Marine Insurance Co., St. Paul, Minn.	8
Pfizer Laboratories, Doraville, Ga.	9
Mead Johnson Laboratories, Evansville, Ind.	10
Sandoz Pharmaceuticals, E. Hanover, N. J.	11
Ayerst Laboratories, New York, N. Y.	12
McNees Medical Supply Co., Jackson, Miss.	13
Bristol Laboratories, Syracuse, N. Y.	14
Comatic Laboratories, Inc., Houston, Tex.	15
Miller Pharmacal Co., Inc., W. Chicago, Ill.	16
Unifirst Federal Savings & Loan Association, Jackson, Miss.	17
U. S. Air Force Medical Services, St. Louis, Mo.	18

USV Pharmaceutical Corporation, Tuckahoe, N. Y. 20
Amid Laboratories, Marion, Ala. 21
Boehringer Ingelheim Ltd., Elmsford, N. Y. . 22
E. R. Squibb & Sons, Princeton, N. J. 23
Jasper Ewing, Jackson, Miss. 25
Encyclopedia Britannica, Inc., Chicago, Ill. . 26
Roche Laboratories, Nutley, N. J. 27
Merrill Lynch, Pierce, Fenner and Smith, Jackson, Miss. 28
The Travelers Ins. Co.-Medicare, Jackson, Miss. 29
The Emko Company, St. Louis, Mo. 30
CIBA Pharmaceutical Co., Arlington, Tex. .. 32
Hoechst-Roussel Pharmaceuticals, Inc., Somerville, N. J. 33
Medical and Corporate Financial, Inc., Jackson, Miss. 34
Deposit Guaranty National Bank, Jackson, Miss. 35
Meyer Laboratories, Inc., Fort Lauderdale, Fla. 37
Wampole Laboratories, Stamford, Conn. 39
Danal Laboratories, Inc., St. Louis, Mo. 40

REGISTRATION FOR EXHIBIT PRIZES

Visit the Technical Exhibits often and qualify for the drawing of attractive prizes. Obtain necessary initials as you visit each booth. Deposit cards at Registration not later than noon on Wednesday. Prizes will be awarded at the exhibitors reception on Wednesday night.

SCIENTIFIC GRANTS

Geigy Pharmaceuticals, Ardsley, N. Y.
A. H. Robins and Co., Richmond, Va.
Eli Lilly and Co., Indianapolis, Ind.

ASSISTANCE WITH SCIENTIFIC PROGRAM

These pharmaceutical manufacturers assisted the following sections with their programs:

Pfizer Laboratories—The Section on Medicine
Merck Sharp & Dohme—The Section on Medicine and The Section on Family Practice
Ross Laboratories—The Section on Pediatrics

SCIENTIFIC PROGRAM

Sunday, May 4, 1975
Grand Ballroom
Beginning at 6:30 p.m.

Carlos S. Patino, Jackson
Chairman

Katherine Aldridge, Hattiesburg
Secretary



DR. PATINO

SHORT COURSES IN:

UNDERSTANDING SICKLE-CELL DISEASE IN ANESTHESIA

William C. North, Professor and Chairman, Department of Anesthesiology, University of Tennessee, Memphis

SCIENTIFIC PROGRAM

Tuesday, May 6, 1975
Empire Room (First Floor)
Beginning at 9:00 a.m.

Larry H. Day, Hattiesburg
Chairman

James W. Rayner, Oxford
Secretary



DR. DAY

SHORT COURSES IN:

GLAUCOMA SURGERY, 1975

Alan I. Mandell, Chief, Glaucoma Service, Department of Ophthalmology, University of Tennessee, Memphis

SURGICAL TREATMENT FOR VERTIGO—SOUND OR FURY?

Gale Gardner, Assistant Professor, Department of Otolaryngology and Maxillofacial Surgery, University of Tennessee, Memphis

INTERPRETATION OF THE OPTIC DISC IN GLAUCOMA

Dr. Mandell

MODERN TEMPORAL BONE SURGERY—FINDING THE KEY

Dr. Gardner

SCIENTIFIC PROGRAM

Tuesday, May 6, 1975
Gulf Room A
Beginning at 9:00 a.m.

Marion L. Sigrest, Yazoo City
Chairman

Hardy B. Woodbridge, Jr., Jackson
Secretary



DR. SIGREST

SHORT COURSES IN:

MANAGEMENT OF IDIOPATHIC SCOLIOSIS
L. Buford Yerger, Jr., Practicing Orthopedist and Clinical Instructor, Department of Surgery, University of Mississippi, Jackson

CONTINUING EDUCATION: A PAUSE FOR REFRESHMENT
Roland B. Robertson, Director of Continuing Health Professional Education, and Assistant Dean for Continuing Education, University of Mississippi, Jackson

OBSERVATION OF THE STONE SEASON
John P. Elliott, Jr., Practicing Urologist and President of the Mississippi Urological Association, Tupelo

THE PROBLEM LIST
J. Phillip Balaski, Chief Resident, Department of Family Medicine, University of Mississippi, Jackson

SCIENTIFIC PROGRAM

Tuesday, May 6, 1975
Empire Room (First Floor)
Beginning at 1:30 p.m.

Thomas E. Waller, Starkville
Chairman

Steven L. Moore, Jackson
Secretary



DR. WALLER

SHORT COURSES IN:

THE CLINICAL ROLE OF THE PHYSICIAN IN OCCUPATIONAL MEDICINE
Howard L. McMartin, Special Assistant for Intragovernmental Affairs, NIOSH, Department of Health, Education and Welfare, Rockville, Md.
and
Gordon D. Nifong, Regional Program Consultant for Occupational Safety and Health, Division of Prevention, DHEW, Region IV, Atlanta

ST. LOUIS ENCEPHALITIS IN MISSISSIPPI IN 1974
Kenneth Powell, State Board of Health, Jackson

SCIENTIFIC PROGRAM

Tuesday, May 6, 1975
Gulf Room C
Beginning at 1:30 p.m.

T. Erskine Ross, III,
Hattiesburg
Chairman

Henry B. Tyler, Jackson
Secretary



DR. ROSS

SHORT COURSES IN:

HEMODYNAMIC PATTERNS IN THE CRITICALLY ILL
John J. Collins, Jr., Associate Professor of Surgery, Harvard Medical School, and Chief of Cardiac and Thoracic Surgery, Peter Bent Brigham Hospital, Boston

PRIMARY TREATMENT OF MAMMARY CARCINOMA
Arthur J. Donovan, Chairman, Department of Surgery, South Alabama Medical School, Mobile

RECOGNITION AND TREATMENT OF INJURIES OF THE HAND
Michael E. Jabaley, Associate Professor of Surgery, and Chief of the Division of Plastic Surgery, University of Mississippi, Jackson

SCIENTIFIC PROGRAM

Wednesday, May 7, 1975
Gulf Room B
Beginning at 9:00 a.m.

George Ball, Jackson
Chairman

Charlton R. Vincent, Laurel
Secretary



DR. BALL

SHORT COURSES IN:

MATERNAL STILBESTROL—VAGINAL ADENOSIS AND CLEAR CELL CANCERS: A STATUS REPORT
Robert W. Swan, Assistant Professor of Ob-Gyn and Associate Director of the Gynecologic Oncology Division, University of Mississippi, Jackson

SUBSPECIALTY DEVELOPMENT OF THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Richard C. Boronow, Professor and Acting Chairman, Department of Ob-Gyn and Director of the Gynecologic Oncology Division, University of Mississippi, Jackson

CURRENT CONCEPTS OF CERVICAL INTRAEPITHELIAL CARCINOMA
Dr. Swan

THE ROLE OF ELECTIVE ABORTION IN THE MANAGEMENT OF UNWANTED FERTILITY
Theodore M. King, Director, Department of Gynecology and Obstetrics, The Johns Hopkins School of Medicine, Baltimore

SCIENTIFIC PROGRAM

Wednesday, May 7, 1975
Gulf Room C
Beginning at 9:00 a.m.

Richard C. Miller, Jackson
Chairman

Robert L. Abney, III, Jackson
Secretary



DR. MILLER

SHORT COURSES IN:

RECENT ADVANCES IN THE THERAPY OF WILMS' TUMOR AND RHABDOMYOSARCOMA
Daniel Hays, Professor of Surgery, U.S.C. School of Medicine, Los Angeles

TUMOR THERAPY PROGRAMS IN MISSISSIPPI—WHAT'S AVAILABLE AND RESULTS TO DATE
Jeanette Pullen, Assistant Professor of Pediatrics, University of Mississippi, Jackson

THE STAGING OF HODGKIN'S DISEASE IN CHILDHOOD
Dr. Hays

Panel Discussion—THE DETECTION AND TREATMENT OF PEDIATRIC MALIGNANCIES
Dr. Hays, Dr. Pullen, and Dr. Patricia Moynihan, Assistant Professor, Departments of Surgery and Pediatrics, University of Mississippi, Jackson

SCIENTIFIC PROGRAM

Wednesday, May 7, 1975
Gulf Room D
Beginning at 9:00 a.m.

James C. Hays, Jackson
Chairman

Joe M. Ross, Jr., Vicksburg
Secretary



DR. HAYS

SHORT COURSES IN:

THE HALF AND HALF FINGERNAIL: A CLUE TO CHRONIC RENAL FAILURE
C. Ralph Daniel, III, Practicing Internist, Jackson (Co-authors: John D. Bower, Associate Professor of Medicine, University of Mississippi, Jackson, and Carlton R. Daniel, Jr., Jackson)

CURRENT CONCEPTS OF THE TREATMENT OF RHEUMATOID ARTHRITIS
Gene G. Hunder, Mayo Clinic, Rochester, Minn.

PROTECTIVE ISCHEMIC MYOCARDIUM
Quinton H. Dickerson, Jr., Practicing Cardiologist, Jackson

TREATMENT OF DIABETES MELLITUS
Jerome R. Ryan, Associate Professor of Medicine, Tulane University, New Orleans

OUT OF STATE ESSAYISTS



JOHN J. COLLINS,
Boston



ARTHUR J. DONOVAN,
Mobile



GALE GARDNER,
Memphis



DANIEL HAYS,
Los Angeles



GENE G. HUNDER,
Rochester, Minn.



HOWARD L. MCMARTIN
Rockville, Md.



THEODORE M. KING,
Baltimore



ALAN I. MANDELL,
Memphis



GORDON D. NIFONG,
Atlanta



WILLIAM C. NORTH,
Memphis



JEROME R. RYAN,
New Orleans

MISSISSIPPI DERMATOLOGICAL SOCIETY

The Mississippi Dermatological Society will hold a business meeting on Sunday, May 4, at 9:00 a.m. in the Gulf Room A. Officers are James M. Brock of McComb, president; Louis J. Wise of Jackson, president-elect; and Ronald R. Lubritz of Hattiesburg, secretary-treasurer.

MISSISSIPPI PSYCHIATRIC ASSOCIATION

The Mississippi Psychiatric Association will hold a luncheon, business meeting and scientific session beginning at 12:00 noon on Sunday, May 4 in Gulf Room B. At 1:00 p.m. Dr. Reginald P. White will discuss "The Misuse of Prescription Drugs." Guests are welcome and tickets may be purchased from Dr. Barbara Goff. S. Ray Pate of Jackson is president and James E. Ruff of Jackson is secretary.

MISSISSIPPI ASSOCIATION OF PATHOLOGISTS

The Mississippi Association of Pathologists will hold a business meeting at 2:00 p.m. on Sunday, May 4, in the Biloxi Room. Hollis Burrow of Greenville is president; Van Philpot of Houston is president-elect; and Julian C. Henderson of Jackson is secretary.

MISSISSIPPI SOCIETY OF ANESTHESIOLOGISTS

The Mississippi Society of Anesthesiologists will meet in the Grand Ballroom on Sunday, May 4, at 6:30 p.m. for dinner and the MSMA Section on Anesthesiology program. Society officers are Carlos Patino of Jackson, president; Katherine Aldridge of Hattiesburg, secretary-treasurer; and James Cooper of Tupelo, president-elect.

REFERENCE COMMITTEE BREAKFAST

Members of all reference committees of the House of Delegates will meet for breakfast on Monday morning, May 5, in Gulf Room D at 7:00 a.m. Hosts are Walter Simmons of Jackson, speaker, and C. D. Taylor of Pass Christian, vice speaker. At this important meeting, committee members will be instructed in their duties and conduct of hearings to be held later in the day.

MISSISSIPPI SPORTS MEDICINE SOCIETY

The Mississippi Sports Medicine Society will hold its organizational meeting on Monday morning, May 5, at 9:30 a.m. in Gulf Room C. James O. Manning of Jackson is in charge of arrangements.

MISSISSIPPI ORTHOPAEDIC SOCIETY

The Mississippi Orthopaedic Society will hold a luncheon and scientific program beginning at 11:00 a.m. in Gulf Room D on Monday, May 5. Officers are James O. Manning of Jackson, president; McWillie Robinson, vice president; L. Buford Yerger, secretary-treasurer; and Sidney R. Berry of Jackson, president-elect.

MISSISSIPPI NEUROSURGICAL SOCIETY

The Mississippi Neurosurgical Society will sponsor a scientific program and luncheon at 11:00 a.m. on Monday, May 5, in the Boston Room. Officers are O. J. Andy, president; Walter Neill, president-elect; and Lucien R. Hodges, secretary.

MISSISSIPPI UROLOGICAL SOCIETY

The Mississippi Urological Society will hold a luncheon and business meeting in Gulf Room C on Monday, May 5 at 12:00 noon. Officers of the society are John P. Elliott of Tupelo, president; William C. Gates of Columbus, secretary-treasurer; and Wafford H. Merrell of Jackson, president-elect.

MISSISSIPPI COMMISSION ON HOSPITAL CARE

The Mississippi Commission on Hospital Care will hold its monthly commission meeting on Monday, May 5, at 2:00 p.m. in the Biloxi Room. Officers are Alton B. Cobb of Jackson, chairman; H. Latham Laws of Columbus, vice chairman; Lowery A. Woodall of Hattiesburg, secretary; and Ernest Moss, Executive Director.

A SHORT COURSE IN PRACTICAL TONOMETRY

The Mississippi EENT Association and the Mississippi Society for the Prevention of Blindness will again conduct a training course in indications and mechanics of tonometry. The course has been approved for one hour of postgraduate credit and will be offered in Gulf Room B at 4:00 on Monday and at 3:00 on Tuesday afternoons.

OLE MISS MEDICAL ALUMNI

University of Mississippi medical alumni, families and guests will meet on Monday, May 5, at the Sheraton-Biloxi. Alumni registration will be located adjacent to MSMA general registration in the second floor lobby and will be open at 10:00 a.m. where tickets for the evening party will be available. A general business meeting will be conducted at 4:00 p.m. on Monday in the Jackson Room. The cocktail party and seafood jamboree will begin at 7:00 on the Top of the Sheraton. Richard B. Ellison of Biloxi is program planning committee chairman. Other committee members are Ray H. Stewart of Biloxi; Louis A. Rubenstein of Ocean Springs; and Thomas R. Singley of Pascagoula. Frank Bowen of Carthage, medical alumni president, will preside. For details and tickets write Bill Price, Alumni House, 2500 N. State Street, Jackson 39216.

TENNESSEE MEDICAL ALUMNI

Medical alumni of the University of Tennessee will enjoy a reception on Monday evening, May 5, in Gulf Room A from 6:00 to 8:00 p.m. Arrangements are being made by Kent E. Dove, UT Associate Director of Development.

TULANE MEDICAL ALUMNI

Medical graduates of Tulane University will be feted at a cocktail reception on Monday evening, May 5, in the Empire Room from 6:00 to 8:00 p.m. Ms. Ellen Smith, Administrative Assistant at Tulane, is aiding in arrangements.

VANDERBILT MEDICAL ALUMNI

Vanderbilt Medical Alumni will gather in the Jackson Room on Monday, May 5, at 6:00 p.m. for a reception.

AMERICAN COLLEGE OF SURGEONS, MISSISSIPPI CHAPTER

The Sheraton-Biloxi
Tuesday, May 6, 1975
ROBERT S. CALDWELL, Tupelo, president
W. BRIGGS HOPSON, Vicksburg, secretary

7:30 a.m. Officers Breakfast, Boston Room

9:00 a.m. Scientific Session, Gulf Room C
"Longevity After Coronary Surgery"
John J. Collins, Jr., Boston
"Pancreatic and Duodenal Trauma"
Arthur J. Donovan, Mobile

12:00 noon Luncheon Meeting, Gulf Rooms C and D

MISSISSIPPI EENT ASSOCIATION

The Mississippi Eye, Ear, Nose and Throat Association will conduct a luncheon meeting on Tuesday, May 6, in the Biloxi Room at 12:00 noon. Association officers are Patrick L. Pierce of Gulfport, president; L. Ben McCarty, Jr., of Jackson, secretary-treasurer; and Daniel H. Moore, Jr., of Meridian, vice president.

MISSISSIPPI ACADEMY OF FAMILY PHYSICIANS

The Mississippi Academy of Family Physicians will sponsor a luncheon meeting at 12:00 noon on Tuesday, May 6, in Gulf Rooms A and B. Guest speaker will be Dr. Richard M. Paddison, professor of neurosurgery at L.S.U. School of Medicine in New Orleans. He will discuss "Relax —Your Pressure Is Too High." Officers of the Mississippi academy are Thomas J. Anderson of Laurel, president; Richard T. Furr of Ocean Springs, president-elect; Walter H. Rose of Indianola, vice president; and Marion L. Sigrest of Yazoo City, secretary.

FIFTY YEAR CLUB

The Board of Trustees, sponsors of the association's Fifty Year Club, will honor the half-century plus members at a special luncheon on Tuesday, May 6, in the Boston Room at 12:00 noon. James O. Gilmore of Oxford, chairman of the Board of Trustees, will preside.

MSMA PAST PRESIDENTS' BREAKFAST

Past presidents of the Mississippi State Medical Association will enjoy a fraternal breakfast on Wednesday morning, May 7, in the Boston Room at 7:30 a.m. Dr. Arthur Derrick of Durant is host.

MISSISSIPPI FOUNDATION FOR MEDICAL CARE

The Mississippi Foundation for Medical Care will hold its annual meeting on Thursday morning, May 8, at the Sheraton-Biloxi. All members are urged to attend.

MISSISSIPPI SOCIETY OF INTERNAL MEDICINE

A luncheon meeting with guest scientific speaker will be conducted by the Mississippi Society of Internal Medicine on Wednesday, May 7, in the Empire Room beginning at 12:00 noon. Officers of the society are Ellis M. Moffitt of Jackson, president; James C. Hays of Jackson, secretary; and A. Robert Dill of Columbus, president-elect.

MISSISSIPPI OB-GYN SOCIETY

The Mississippi Ob-Gyn Society will conduct a luncheon meeting on Wednesday, May 7, in the Boston Room at 12:00 noon. Society officers are Ira E. Gaddy of Gulfport, president; Richard S. Hollis of Amory, vice president; Kenneth P. Pittman of Jackson, secretary-treasurer; and Calvin Hull of Jackson, president-elect.

ASSOCIATION PARTY

Members of the Mississippi State Medical Association, their families and guests will enjoy a cocktail party on Wednesday evening, May 7, in the Gulf Rooms at 7:00 p.m. There is no dinner or program, just good fellowship. Tickets will be available at general registration on the second floor lobby.

WOMAN'S AUXILIARY TO THE MISSISSIPPI STATE MEDICAL ASSOCIATION

52nd Annual Session The Sheraton-Biloxi
May 4-7, 1975



MRS. REIKES



MRS. HILL

OFFICERS

MRS. DAN REIKES
Hattiesburg, President

MRS. J. EDWARD HILL
Hollandale,
President-elect

MRS. W. MONCURE DABNEY
Crystal Springs, Treasurer

Mrs. T. Erskine Ross, III
Hattiesburg

Mrs. A. T. Tatum
Petal

Co-Chairmen

Mrs. Jack D. Daniel, Hattiesburg
Luncheon Chairman

AUXILIARY

Sunday, May 4, 1975

2:00-6:00 p.m. Registration and Hospitality, Lobby, Lower Level

Monday, May 5, 1975

9:00 a.m. to 5:00 p.m. Registration

10:30 a.m. Finance Committee Meeting, Gulf Room B

3:00 p.m. Preconvention Board Meeting, Boston Room

Tuesday, May 6, 1975

8:00-9:00 a.m. Continental Breakfast, Grand Ballroom

9:30 a.m. General Session, Grand Ballroom
- Invocation
- Welcome
- Response
- Introductions
- Greetings
  - Dr. J. T. Davis, President, MSMA
  - Dr. Jack Atkinson, President-elect, MSMA
  - Mrs. James Manning, President, WA/Southern Medical Association
  - Mrs. Ben H. Johnson, Jr., Director, WA/Southern Medical Association
- Guest Speaker—Mrs. Ben H. Johnson, Jr.
- Roll Call
- Minutes
- Reports
- Appointment of Delegates to the WA/AMA Annual Meeting
- Business
- Election of Officers
- Installation of Officers—Mrs. James Manning
- Memorial Service
- Courtesy Resolutions
- Adjournment

1:00 p.m. Luncheon, Top of the Sheraton
- Invocation
- Introductions
  - Guest Speaker—Dr. Malcolm Todd, President, American Medical Association
- Presentation of Officers
- Awards

Adjournment

3:30 p.m. Postconvention Board Meeting, Jackson Room

Wednesday, May 7, 1975

9:00 a.m. Past Presidents' Breakfast, Biloxi Room

10:00 a.m. Workshop for County Presidents and Presidents-elect, conducted by Mrs. Ben J. Johnson, Jackson Room

AAP Receives Head Start Consultation Grant

The American Academy of Pediatrics has been awarded a one-year, $1.8 million contract for continuation of its nationwide medical consultation service for federally-funded Head Start early childhood education projects.

The contract was awarded by HEW's Office of Child Development (OCD) and provides for the services of 14 regional health liaison specialists as well as hundreds of local Head Start medical consultants.

The health liaison specialists will work with regional OCD offices throughout the country to assure the coordination of the health programs in local Head Start projects. The specialists will visit local programs and work with their health advisory committees, helping to identify resources and materials, conducting workshops on special problems, and evaluating the effectiveness of each program's health component.

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EQUIPMENT — FURNITURE



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Pro-Banthine®
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Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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Address medical inquiries to: G. D. Searle & Co.
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Handbook of the House of Delegates

Mississippi State Medical Association
107th Annual Session, Biloxi
May 5-8, 1975

SUPPLEMENTAL REPORT A
OF THE SECRETARY-TREASURER

Vacancies in Elected Offices. Effective May 8, 1975, there will occur 25 vacancies in elected offices in the association by reason of expiration of prescribed terms of service. In accordance with the by-laws the nominating committee will be asked to deliberate, consult with colleagues, and make nominations to the House of Delegates for consideration and voting to elect successors or to re-elect incumbents. The nominating committee will hold an open meeting on Wednesday, May 7, 1975, for this purpose.

Eligibility. To be nominated for office in the association, a nominee must have been a member for two years, be in present good standing as a member, and must have attended two-thirds of the past two and current annual sessions.

Vacancies for Nomination. Following is the listing of vacancies that will occur during the 107th Annual Session as well as requirements for nominations and identity of incumbents:

President-Elect

Nominate three, no two of whom may be from the same county, elect one.

Vice Presidents

Nominate three for the northern area, three for the mid-state area, and three for the southern area. Elect one for each area.

Speaker, House of Delegates

Term 1975-78. Nominate three, elect one. Incumbent: Walter H. Simmons, Jackson.

Vice Speaker, House of Delegates

Term 1975-78. Nominate three, elect one. Incumbent: C. D. Taylor, Jr., Pass Christian.

Delegate to AMA

Term Jan. 1, 1976-Dec. 31, 1977. Nominate two, elect one. Incumbent: G. Swink Hicks, Natchez.

Alternate Delegate to AMA

Term Jan. 1, 1976-Dec. 31, 1977. Nominate two, elect one. Incumbent: Stanley A. Hill, Corinth.

HANDBOOK INFORMATION

The speaker and vice speaker of the House of Delegates herewith present for the information of all members those reports and resolutions as have been received for publication in advance of the 107th Annual Session. It is the intent of this advance publication to inform the membership and to afford all concerned the opportunity to confer with delegates over any aspects of the reports and resolutions.

No report or resolution herein becomes official or a statement of policy until formally presented to the House of Delegates and acted upon at the annual session.

WALTER H. SIMMONS
SPEAKER
C. D. TAYLOR, JR.
VICE SPEAKER

Associate Editor

Term 1975-77. Nominate two, elect one. Incumbent: Myron W. Lockey, Jackson.

Board of Trustees, Districts 7, 8, and 9

Terms 1975-78. Nominate two for each district, elect one for each district. Incumbents: Gerald P. Gable, Hattiesburg, District 7; Everett Crawford, Tylertown, District 8; and James T. Thompson, Moss Point, District 9.

Council on Budget and Finance

Terms 1975-78. Nominate four, elect two, two vacancies. Incumbents: J. Daniel Mitchell, Jackson; and David L. Clippinger, Gulfport.

Council on Constitution and By-Laws

Term 1975-78. Nominate two, elect one. Incumbent: Tom H. Mitchell, Vicksburg.

HOUSE OF DELEGATES / Continued

Judicial Council, Districts 4, 5, and 6

Terms 1975-78. Nominate two for each district, elect one for each district. Incumbents: James E. Booth, Eupora, District 4; Samuel B. Johnson, Jackson, District 5; and Charles M. Moore, Philadelphia, District 6.

Council on Legislation, Districts 7, 8, and 9

Terms 1975-78. Nominate two for each district, elect one for each district. Incumbents: A. T. Tatum, Petal, District 7; Everett Crawford, Tylertown, District 8; and C. D. Taylor, Jr., Pass Christian, District 9.

Council on Medical Education

Term 1975-78. Nominate two, elect one. Incumbent: Dennis E. Ward, Corinth. (Ineligible for reelection by reason of serving three consecutive terms.)

Council on Medical Service, Districts 1, 2, 3

Terms 1975-78. Nominate two for each district, elect one for each district. Incumbents: John F. Lucas, Jr., Greenwood, District 1; John R. Loveland, Batesville, District 2; and Joseph R. Henry, New Albany, District 3.

Mississippi State Board of Health

Term January 1, 1976-December 31, 1981. Nominate six for each district, vote for three.

Public Health District 2 (comprised of these counties: DeSoto, Tate, Panola, Lafayette, Benton, Tippah, Tallahatchie, Marshall, Union.)

Incumbent: G. Lacey Biles, Sumner

Public Health District 4 (comprised of these counties: Yalobusha, Grenada, Montgomery, Attala, Pontotoc, Chickasaw, Clay, Calhoun, Webster, Choctaw, Carroll.)

Incumbent: S. Lamar Bailey, Kosciusko

Public Health District 5 (comprised of these counties: Newton, Lauderdale, Smith, Jasper, Winston, Leake, Neshoba, Kemper, Clarke, Scott.)

Incumbent: Lamar Arrington, Meridian. (Ineligible for nomination by reason of serving two consecutive terms.)

REPORT OF THE DELEGATES TO AMA

This reporting covers the 123rd Annual Convention at Chicago, June 22-27, 1974, and the 28th Clinical Convention at Portland, Oregon, Nov. 30-Dec. 4, 1974. Your delegation is indebted to our president and other officers and members who participated in these conventions and worked with us.

Chicago Annual Convention. A change in the method of electing AMA Trustees, a definitive policy statement on PSROs, the need for additional safeguards to preserve the confidentiality of medical records, and new recommendations which affect the relationship between hospitals and hospital medical staffs were among the important items approved by Delegates at the 123rd Annual Convention in Chicago.

Meeting for a total of 19 hours and 38 minutes, the House acted on 66 reports and 137 resolutions for a total of 203 items of business.

The House approved bylaws changes which replace the "slot method" of electing trustees by the "simultaneous election of candidates to several positions of equal rank," in which all candidates run for board vacancies on a single ballot.

Under the new method, trustees for full, three-year terms are elected first, followed by the selection of trustees to fill unexpired terms. Election of the AMA president-elect, vice-president, and speaker and vice-speaker of the House remains on a separate basis. Delegates selected Max Parrott of Portland, Oregon, as president-elect.

Speculation over possible changes in PSRO policy by the House dominated the attention of those attending the convention, including the media.

During its day-long hearing on Monday, June 24, Reference Committee A considered two reports and 25 resolutions bearing on the issue, and estimated that 64 speakers addressed themselves to PSRO.

But on Wednesday, the Delegates—cognizant of the hours of debate devoted to PSRO at Anaheim last December and in New York City last June—overwhelmingly voted (202 to 24) to terminate debate after a few minutes.

Then the House adopted a substitute resolution on PSRO proposed by the reference committee, whose members emphasized that the resolution provides the association with a "clear-cut, definitive position which cannot be misunderstood by anyone inside or outside this House of Delegates." The resolution:

—Instructs the Board of Trustees to seek constructive amendments to the PSRO program, par-

ticularly in potentially dangerous areas such as confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW.

—Directs the AMA to continue efforts to achieve legislation which allows the profession to perform peer review according to established medical philosophy and the best interests of the patient.

—Emphasizes that state associations which elect non-compliance with PSRO are not prevented from doing so by the new policy, but urges such associations to develop effective non-PSRO review programs embodying the principles endorsed by the profession as constructive PSRO alternatives.

The new policy also provides that in the event that the PSRO program does, in fact, adversely affect patient care or conflict with AMA policy, then "the Board of Trustees (will) be instructed to use all legal and legislative means to rectify these shortcomings."

Two statements on national health insurance were adopted after lengthy debate. One calls on the Board of Trustees to cooperate with state associations "to attempt to devise mechanisms mutually acceptable to the private medical and insurance communities which will ensure the provision of health insurance coverage through the purchase of private health insurance, and to seek means to secure favorable Congressional and public support for their adoption."

During discussion, it was pointed out that the addition to the NHI policy does not affect AMA support for Medicredit, but is intended to stimulate new health insurance mechanisms. The second resolution calls on the AMA and component associations to work to detach "any national health insurance program from the controlling intrusions of existing PSRO laws and regulations."

The House adopted two resolutions bearing on drugs. One directs the AMA to continue its support of the pharmaceutical industry in efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy. The other resolution directs the AMA to "exert all efforts to amend or repeal the Kefauver-Harris" drug amendments of 1962, which gave the FDA broad new powers in drug manufacturing and marketing, and which critics of the FDA contend has tended to stifle the developing and marketing of new drugs in the United States.

The House went on record as being opposed to certain bills in Congress which would replace the federal "Health Professions Educational Assistance Act" which expired June 30. Under the bills, comprehensive health planning programs would be replaced with public utility type bodies which would control certain aspects of health education and health care delivery, and medical licensure. An amended resolution adopted by the House directs the Board of Trustees to mobilize AMA membership in opposition to offensive sections of the proposed legislation, and take strong actions on other fronts.

In other actions affecting physicians and the government, and other third parties, the House:

—Directs the AMA to seek an extension of from 30 to 90 days to respond to proposed health regulations printed in the *Federal Register,* and that government agencies using the *Federal Register* for rule-promulgating purposes be urged to hold public hearings on the merits of proposed legislation.

—Calls on the AMA to oppose the concept of claims rejection on the basis of "diagnostic admission" or "lack of medical necessity" without prior physician notification, and to recommend a peer review mechanism be established independent of the third-party carrier to review claim conflicts with such mechanisms to be established by existing medical foundations, medical societies or other independent peer review organizations.

—Requests the AMA to work with third parties to secure increased acceptance of the AMA uniform health insurance claim form, and urges state associations to encourage acceptance of the form by insurance commissioners, and, if necessary, through state legislation.

—Urges continued AMA efforts to prevent future imposition of government fee controls, and opposes the mandatory imposition of a "Healthcard" as the payment mechanism under the Administration's national health insurance plan, and instead, reaffirmed the right of the physician to bill patients directly.

The House adopted two reports bearing on confidentiality of medical records. Report I of the Council on Medical Service describes a wide-ranging series of proposals to enable the medical profession and insurance companies to "maintain the confidentiality and security of patient information." Report S of the Board of Trustees notes that the Council on Legislation is developing model legislation as a guide to possible state legislation to preserve confidentiality, and that a model bill should be ready for

consideration by the House at the 1974 Clinical Session in Portland, Oregon.

The House adopted the 104-page "Report on Physician-Hospital Relations, 1974," compiled by the Council on Medical Service and its Committee on Private Practice. An update of an earlier report made in 1964, the 1974 version contains 14 specific recommendations to cope with problems developing between some hospitals and their medical staffs. Among other things, the recommendations are aimed at protecting medical staffs against unilateral action by hospital governing boards relative to staff bylaws, rules, and regulations. The report was considered by the MSMA House of Delegates at our 106th Annual Session, May 1974.

Two informational reports dealing with possible guidelines for housestaffs in developing contracts in institutions in which they serve generated considerable discussion before Reference Committee C. Among those testifying were medical students, residents, faculty members, hospital directors, and members of the AMA's Board of Trustees and Council on Medical Service. Because of the importance and the complexity of the issues involved, the two reports, plus a revised report submitted by the Intern and Resident Business Session during the convention, were referred to the Board of Trustees for further study and consultation with appropriate groups. Delegates directed the Board to report back at the 1974 Clinical Session.

The House adopted a resolution calling for the AMA, through appropriate committees and councils, to assure due process for medical students, and requested a further report at the next clinical session.

Another resolution proposing guidelines for "Fair, Professional Relationships between Training Institutions and House Officers" (intended for inclusion in the essentials of approved internships, and residencies) was referred for further study and report back at the clinical session.

The House adopted a resolution calling on the AMA to encourage—and urging medical schools to implement—a series of lecture programs for students on the socio-economic aspects of medicine.

Portland Clinical Convention. A mandatory, special assessment of $60 for AMA members was approved by the House of Delegates at the 28th Clinical Convention in Portland. The assessment, effective Jan. 1, 1975, for AMA members excluding students, interns, and residents, was expected to improve immediate cash-flow problems and help build up depleted financial reserves. Rejecting a $90 dues increase proposed by the Board of Trustees, delegates instead called for a special committee of the House to study the dues issue and report back at the 1975 annual meeting.

The price of defending medical freedom can be high, but that price must be paid, AMA President Malcolm C. Todd, M.D., told delegates at the Clinical Convention in Portland.

Equating the "freedom that has made American medicine the most creative in the world" with the "very essence of professionalism cherished so highly by the nation's physicians," Dr. Todd pointed out that medicine's freedom, and hence its professionalism, are threatened.

Chief among the threats are various legislative proposals which would impose a compulsory national health insurance system, would make health care a public utility to "reduce each of us to the level of an electric wire or a telephone line," and manpower bills that would "imply indentured service in medical education."

Only a strong AMA can counter such threats and preserve professionalism, Dr. Todd emphasized, but "it is impossible for its strength to be any greater than its finances."

Therefore he issued a strong appeal to the House to support a $90 dues increase, or as an alternative, a special assessment.

While admitting that the AMA was not 100 per cent effective legislatively, he said that "No element in society has a perfect score. Any element has to set its sights not on the best of all possible worlds, but the best of all possible realities."

He said that if the AMA is to be effective in seeking a national health insurance plan that would "respect both public needs and professional competence" in countering overly-stringent health planning and manpower bills and in mitigating malpractice problems, then "it will need the money."

In assessing a mandatory $60 special assessment effective Jan. 1, the delegates acted to strengthen AMA finances.

The House was reminded that the association has operated at a deficit for four of the last five years and that cash reserves have been seriously depleted during that time. In addition, AMA finances in 1974 were adversely affected by inflationary pressures.

After almost six hours of comment and deliberation on Tuesday afternoon and Wednesday morning, the delegates adopted the $60 special assessment as a stop-gap measure.

The question of a dues increase was referred to a special committee of the House to be appointed by the speaker. The committee will make a comprehensive study of the AMA's financial priorities and capabilities and report to the House at the 1975 annual meeting.

In related actions the House strongly urged the Board of Trustees to restore in a "holding pattern" the structure of several councils and committees which were to have been eliminated and to maintain present publication schedules for *JAMA*, all specialty journals, and *Prism*.

The House also approved advertising as a legitimate function in AMA publications and urged that the present full and unrestricted advertising program in AMA publications continue pending further study and a report at the June meeting.

During a discussion of malpractice problems, the House adopted a recommendation calling for the Board to give "priority attention" to providing legal counsel and advice to AMA members and state societies in the event their professional liability insurance is not renewed.

The House also emphasized the necessity for state associations to seek legislative remedies for malpractice problems and directed that the AMA continue to cooperate with the medical liability commission.

A separation of the fall business meetings of the House and the scientific meetings will be permitted beginning in 1977.

Under bylaws changes adopted by the House in Portland, the House will hold its fall meeting separately in cities recommended by the Board and selected by the House, and the scientific session will hold regional meetings at other times during the year as deemed necessary by the Board and at cities selected by the Board.

The new format was devised to allow regional scientific programming. The scientific assemblies will continue to be held in conjunction with annual meetings, however.

The House adopted several recommendations which reaffirm the rights of all physicians including housestaff and medical students to due process. In related actions the House adopted as AMA policy the proposition that a student's academic records should be open to inspection so that he/she may profit educationally; and referred back to the judicial council for further study a report involving three cases of alleged violation of due process at the local level.

The House adopted a set of revised guidelines for housestaff contracts. The proposed guidelines as revised had been approved by the Council on Medical Education, the Board of Trustees, and the Council on Medical Service.

Delegates also adopted a Board report calling for strong programs of continuing medical education and peer review as alternatives to relicensure since "the difficulties inherent in relicensure clearly outweigh any potential benefits."

Specific recommendations include all possible encouragement and support for the AMA, constituent societies, JCAH, and other bodies in expanding CME programs; that the AMA give high priority to enhancing and reviewing effective methods of continuing competence; that patient satisfaction should be included in performance evaluation; and that well-designed peer review programs be endorsed as an important component of performance evaluation. The House also stressed that evaluation of performance rather than knowledge per se is the best method of appraising competence in patient care.

In other actions related to physicians and hospitals and medical schools, the House:

—Adopted an amended resolution which urges that duplication of local peer review procedures be avoided; that medical audit or utilization protocols used in screening be limited to those which are demonstrated to be valid, reliable, and which do not add needlessly to cost; and that when local peer review groups recognize that a hospital medical staff has adequate medical audit and utilization procedures, that fact should be recognized by governmental agencies and JCAH.

—Adopted a Board report detailing legally approved methods for the exchange of information between and among medical societies and hospitals concerning a physician's hospital privileges or practice.

—And requested that a "comprehensive report" be presented at the 1975 annual meeting on questions and issues related to foreign medical graduates.

In other actions related to physicians and the government (and third parties), the House:

—Objected to language in insurance letters indicating the claims were "not medically necessary" since this encourages patients to decline to pay for services and is defamatory to physicians.

—Urged that medical intermediaries adhere strictly to regulations for reimbursement of chiro-

practors to those procedures defined in the regulations.

—Encouraged the acceptance and use by physicians of the AMA's Uniform Health Insurance Claim Form, and urged insurors to study the possible use of plastic "charge card" type identification cards for imprinting basic data on insurance forms.

—And urged the government to continue its present 55 m.p.h. speed limit for at least a one-year period noting that traffic fatalities have declined 14.8 per cent since the speed limit was imposed last year.

The House took a strong policy position against the use of human chorionic gonadotropin for use in weight reduction. The House further resolved "that the AMA warn our citizens about the potential danger of such a weight control program." Clinics utilizing chorionic gonadotropin have been established and widely advertised in various parts of the country.

The House adopted two reports that reaffirm AMA policy to encourage insurance coverage of the newborn from the moment of birth, urge the health insurance industry to offer coverage for obstetrical care and any complications, and recommend that the insurance industry—as well as government—offer such coverage on the broadest possible basis.

In other actions relative to physicians and the public, the House:

—Supported state legislation to regulate the practice of acupuncture. The new policy says acupuncture should only be performed in research settings by a physician or under the direct supervision of a physician.

—Reaffirmed AMA endorsement of the flouridation of water supplies.

—Adopted a judicial council report which holds that "It is not unethical for a physician to authorize the listing of his name and practice in a (community) directory for professional or lay use which is intended to list all physicians in the community on a uniform and nondiscriminatory basis. The listing shall not include any self-aggrandizing statement or qualitative judgment regarding the physician's skills or competence."

—Endorsed the right of a physician to dispense ampicillin-probenecid for gonorrhea patients, reflecting a judicial council opinion that physicians have a duty to protect the confidentiality of patients who contract gonorrhea.

—And adopted a substitute resolution calling for the government to develop adequate safeguards for the transportation and storage of hazardous materials such as radioactive materials.

REPORT OF THE BOARD OF TRUSTEES

Organization and Duties—The Board of Trustees is the executive and governing body of the state medical association during vacation of the House of Delegates. It is additionally charged with the duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties the Board shall have conducted five meetings during the 1974-75 association year and met daily during the annual session as required by the association's by-laws. Eight officers sit with the Board of Trustees at all meetings. They are the president, president-elect, immediate past-president, secretary-treasurer, speaker, vice speaker, and the two AMA delegates.

This annual report includes actions on matters referred to the Board by the House of Delegates and items relating to the management and policy functions which are among the Board's responsibilities.

Referrals From the House of Delegates—Matters referred to the Board of Trustees at the 106th Annual Session, 1974, and actions by the House requiring further consideration and implementation include:

Amendments to the MSMA Constitution and By-Laws—Amendments to the MSMA constitution and by-laws dealing with annual session attendance requirements for election to office, reapportionment of association districts, composition of the Board of Trustees, and tenure of Board and council members are "on the table" for action at the 107th Annual Session and are the subjects of a report from the Council on Constitution and By-Laws.

Address of the President—In his address to the House of Delegates at the 106th Annual Session, president Arthur A. Derrick recommended and the House concurred in appointment of a committee to study and report to the House of Delegates recommendations concerning compensation of elected officers of the association and methods for strengthening the component societies of the association as organizational entities. A special committee was formed for this purpose and its report will be presented to the House of Delegates.

Defining the Legal Status of Health Mainte-

nance Organizations (HMOs)—Approval for the association to furnish leadership and guidance in defining the legal status of HMOs in Mississippi has been implemented and is the subject of a report from the Board concerning 1975 legislative activities.

Annual Registration of Physicians' Licenses—A recommendation that the Board study the matter of the association's supporting annual registration of physicians' licenses is the subject of a report from the Board concerning 1974 legislative activities.

MPAC Support of Local Candidate Committees—A recommendation that the Mississippi Medical Political Action Committee initiate and support local candidate committees during this year's legislative races is the subject of a report from the Board concerning MPAC activities.

MSMA Membership Dues Increase—Approval of a $25 increase in MSMA membership dues effective 1975 has been implemented.

Scheduling of 1976 Annual Session in Jackson—A recommendation to schedule the 1976 Annual Session in Jackson and thereafter meeting on the gulf coast in odd numbered years and in Jackson in even numbered years has been implemented.

Resolution No. 4—This resolution directed the establishment of a section on anesthesiology. The section on anesthesiology begins meeting at the 107th Annual Session.

Resolution No. 5—This resolution directed the association to support legislation to modernize admission laws to mental hospitals in Mississippi and is a subject in a report from the Board concerning 1974 legislative activities.

Resolution No. 8—This resolution urged moderation in increasing professional fees upon expiration of the Economic Stabilization Act on April 30, 1974. Such moderation has been stressed in numerous publications to the membership from MSMA and the AMA.

CHAMPUS—The association enters its 19th year as fiscal administrator for CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). A 14-member physician committee serves as the review committee for the program. CHAMPUS continues to grow with an increase in claims and dollar volume during 1974. Based on program policies, CHAMPUS reimburses participating physicians at the 90th percentile of usual, customary, and reasonable charges in Mississippi.

Insurance Programs—The association continues to sponsor a hospitalization group program with Blue Cross and Blue Shield of Mississippi, general accident, disability, health and life groups with the Continental Casualty Company, and a professional liability program with the St. Paul Companies.

The Continental Casualty Company group programs are administered by Thomas Yates and Company of Jackson. Improvements in these contracts during the year as announced to all MSMA participants included a 20 per cent increase in term life benefits without extra cost and allotment of additional coverage under the disability overhead plan without proof of insurability.

The St. Paul professional liability insurance program underwent a major policy change during the past year reflective of the malpractice crisis that has occurred over the past several years. Effective in 1975 the St. Paul Company will only underwrite professional liability on a yearly claims reported basis and will offer a policy for claims not reported when the insured physician retires or ceases being insured by St. Paul. In prior years St. Paul has written professional liability insurance on an "occurrence basis" covering both claims reported and claims occurring during the policy period but not reported until later. In addition to this major change the malpractice insurance premium continues to increase.

The Board has acted to appoint a committee on professional liability insurance to study and recommend solutions to the malpractice crisis. The Board views the work of this committee as timely and important for the future of the practice of medicine and health care of the public in Mississippi.

Budget and Finance—The Council on Budget and Finance met in December 1974 and prepared the 1975 association budget which was presented to the Board in accordance with established procedure. The budget will be presented to the House of Delegates as a part of the annual report of the secretary-treasurer.

Legislative Program—The 1975 Regular Session of the Mississippi Legislature convened in Jackson on Jan. 6, 1975. The Council on Legislation met prior to the session for the purpose of organizing the association's legislative program. Other activities have included production of the weekly "MSMA Legislative Report," continuation of the Emergency Medical Care Unit at the Capitol, coordination of a physicians' legislative contact committee, and up-

(Turn to page 132)



The President Speaking

Confidentiality

J. T. DAVIS, M.D.
Corinth, Mississippi

THE ISSUE OF confidentiality between doctor and patient, so severely trampled in recent years by third party intrusion into the private practice of medicine, now shows signs of emerging as a "backlash" with far reaching implications to third parties and patient alike.

The issue not only strikes at the very heart of successful implementation of the PSRO program in the respective states, but may well prove to be a potent aggravating factor in the medical liability crisis that is seriously threatening the cost and availability of quality medical care to this nation. The success of the review system, the basis of the PSRO program, depends primarily upon the cooperation of the private physician. Without the leadership and united efforts of the medical profession little can be accomplished.

The broad powers of the Secretary of HEW, authorized by Public Law 92-603, to regulate the PSRO program, must be carefully exercised to protect the conscientious efforts of those primarily concerned in its implementation and still guard the interest of the patient.

The activities, decisions and communications of the review mechanism must be held aloof from the usual medical record of the hospital and immune from legal subpoena. Without this protection the review system will become meaningless and further expose the physician and review committee to unwarranted litigation and thus become an easy prey to the less discrete members of the legal profession, who view the medical care field as a happy hunting ground.

To compound the problem many of the former insurance carriers for malpractice insurance have abandoned the field. Others have increased premiums to astronomical heights or have offered limited protection policies. This crisis poses a grave threat to quality medical care and an expensive addition to the cost of defensive medical practice, that eventually the patient must pay.

Confidentiality of medical information must begin and be maintained at the local level to preserve the private patient's record and to serve in some measure as protection for the reviewing committee. With proper protection the review system will ferret out many of the "existing deficiencies" for correction, promote quality medical care and hopefully serve as cost containment, the basic purpose of the PSRO program. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVI, NUMBER 4
APRIL 1975

EDITORIALS

The Government and Health Programs

P.L. 93-641, National Health Planning and Resources Development Act of 1974, is now law. It passed both houses of congress and was signed by the President within a 3 day period in what appears to be rather precipitous action and is now being implemented. It is surely the fore-runner of national health insurance and as surely as further federal intervention in the health care system continues so will the cost of medicine increase. With sophisticated and costly procedures being developed almost daily it is nearly inconceivable to this writer that the federal government can underwrite the cost of total health care for every citizen. Regardless of whether the federal government acts as or designates the third party the results will be very similar.

Organ transplants, artificial kidneys, vascular evaluation and repair, particularly of the heart, are costly procedures or instruments. The care and treatment of cirrhosis, emphysema, drug addiction, all largely self induced, can amount to vast sums in our total population and most of these latter are in non-productive people who likely will remain so. The concept that it is "the right of every citizen to equal access to quality medical care" needs be examined.

One end result of most H.E.W. programs is increasing dependence on a government that has a poor "track record" for efficiency with gradual destruction of self reliance in its citizens and erosion of their moral fiber.

W. Moncure Dabney, Editor
Crystal Springs, Miss.

Scabies: "The Itch"

Scabies, the age-old affliction called "the itch" or "the seven-year itch" appears to be on the increase in many areas of the United States. Outbreaks of this contagious disease of the skin have been recently reported among school children in Mississippi. Scabies is no respector of socioeconomic status; all physicians and school nurses should maintain a high index of suspicion for scabies.

Scabies is transmitted from person to person through skin-to-skin contact, and to a lesser extent through contaminated clothing and bedding. If one family member has scabies, it is highly likely that other members of the family have it and all should be treated at the same time. Transmission between families generally occurs via children who have close contact as playmates; therefore, it would be advisable for close non-family contacts to be examined. Transmission appears to be minimal in school, although close playmate contact could lead to some spread in that setting as well.

Untreated, scabies may persist for decades, but treatment is nearly 100 per cent effective provided that the simple details are strictly followed. All members of the family should receive treatment at the same time to assure eradication of scabies from the household. Each member must take a hot soapy bath and vigorously scrub infected areas. After drying with a clean towel, one per cent lindane cream or lotion (Kwell) should be applied to every millimeter of skin from the neck down to the toes and left undisturbed by washing for 24 hours. At that time, another thorough bath should be taken, using fresh towels and wash cloths, and clean clothing put on. It is advisable to repeat this treatment in one week. Clothing, bedclothes, blankets, towels, and wash cloths should be laundered thoroughly and

frequently. Hot ironing helps to kill the mite. Unless complete cooperation is achieved, the infestation will persist to torment the family.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

LETTERS

SIRS: In view of the current epidemic of scabies, may I make one suggestion to the readers of the JOURNAL? My first teacher of dermatology told me: "When even two people come in with the same disease, think of scabies first." I was telling this to a medical student in my office recently when two brothers entered the office. They had scabies. The fact is I saw three patients with scabies that day.

There is a need for effective treatment of this disease. Maybe one of the readers of this JOURNAL will come up with a remedy we all could use.

CHARLES W. CACCAMISE, JR.
Jackson, Miss.

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

April 7-11, 1975

PULMONARY MEDICINE INTENSIVE COURSE

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from Mississippi Regional Medical Program.

Coordinators:

Joe R. Norman, M.D., professor of medicine, Christmas Seal Professor of Pulmonary Disease, director of the Pulmonary Division and associate professor of physiology-biophysics, the University of Mississippi School of Medicine

A. W. Conerly, M.D., assistant professor of medicine and director of respiratory therapy, the University of Mississippi School of Medicine

Course focus will be on an integrative approach to the more common pulmonary problems the primary care physician encounters. Formal lectures will cover respiratory failure, asthma, ventilators, tuberculosis and fungal disease. Daily rounds will emphasize physical diagnosis, pathophysiology, and diagnostic techniques. A morning of transnasal bronchoscopy will be included. The annual Boswell lecture will be presented on Friday.

April 7-11, 1975

NEWBORN VENTILATOR COURSE I

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center Department of Pediatrics, Division of Newborn Medicine and Division of Continuing Health Professional Education with support from Mississippi Regional Medical Program and the Public Health Service, Department of Health, Education, and Welfare

Coordinator:

John E. Rawson, M.D., assistant professor of pediatrics and director of the Newborn Center, the University of Mississippi School of Medicine

This course deals with indications for and ways to use ventilator therapy with the newborn.

April 14-18, 1975

NEPHROLOGY INTENSIVE COURSE

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from Mississippi Regional Medical Program

Coordinator:

John D. Bower, M.D., associate professor of medicine, director of the Artificial Kidney Unit, and assistant professor of physiology-biophysics, the University of Mississippi School of Medicine

This clinically oriented course will emphasize the reversible and treatable forms of kidney disease. The management of acute kidney failure and the control of the reversible features of chronic kidney disease will be presented in depth. The management of pyelonephritis, glomerulonephritis, nephrotic syndrome, fluid and electrolyte problems, and acid base balance will be covered. The participants will become familiar with physiology, pathology, radiology, immunology, urology, transplantation and hemodialysis in clinical nephrology.

April 21-25, 1975

RADIOLOGY INTENSIVE COURSE

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from Mississippi Regional Medical Program

Coordinator:
Robert D. Sloan, M.D., professor of radiology and chairman of the department, the University of Mississippi School of Medicine

The course will include practical observations of radiologic procedures in the diagnostic, therapeutic, and isotope areas, as well as sessions dealing with equipment, techniques, artifacts, and radiation safety. Participants will play an active role in diagnostic conferences demonstrating practical points of radiographic interpretation, and stressing both the value and limitations of clinical radiology.

All intensive courses are offered through the University of Mississippi Medical Center Division of Continuing Health Professional Education, with partial support from Mississippi Regional Medical Program, pharmaceutical firms, volunteer health agencies, and private donations. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged for each. Fee for the Newborn Ventilator Course is $15.00.

FUTURE CALENDAR

May 5-8, 1975
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

May 7-9
CARE OF THE NEWBORN

May 19-23
FAMILY PRACTICE REVIEW

May 21-23
NEWBORN VENTILATOR COURSE II

Medico-Legal Briefs

REFERENCE TO DOCTOR'S INSURANCE COVERAGE WARRANTS NEW TRIAL

In a medical malpractice suit an attorney's closing argument referring to an osteopath's insurance coverage and appealing to the jury's sympathy on economic disparity was reversible error, a Florida appellate court ruled.

The osteopath had performed a bilateral vasectomy on a patient who had a history of bleeding. The patient had been allowed to leave the osteopath's office after the operation while he was still bleeding. He returned two days later, still bleeding, and the osteopath merely prescribed an antibiotic and recommended application of ice packs. Several physicians who testified for the osteopath admitted that the patient's ultimate loss of a testicle was caused by excessive bleeding. The jury returned a verdict of $40,000 for the patient and $5,000 for his wife.

On appeal, the Florida court said that the patient had made a case sufficient to go to the jury, which was entitled to conclude that the osteopath had failed to take appropriate precautions to control the patient's bleeding. However, the verdict must be reversed because of prejudicial and inflammatory remarks made by the patient's attorney in his closing argument, the appellate court said.

The attorney had commented that the patient did not have the resources to compete with the osteopath and his insurance company in bringing expert witnesses to testify. He also said that a verdict against the osteopath would not affect his ability to practice. It would only call for his insurance company to pay the verdict. The final objectionable remark was that when the trial was over, the osteopath's attorney could "go back to defending doctors and insurance companies and we can all walk away from the case and forget it. But there are two people in this courtroom who can't walk away and forget it. . . ."

It was permissible for a jury to be told that an insurance company was involved in defending the lawsuit against the osteopath, the court noted. However, counsel could not suggest to the jury that insurance coverage was available to pay any judgment that might be awarded against the osteopath, the court said. The attorney's remarks were clearly improper on that ground and for their cumulative effect in appealing to the passion and the prejudice of the jury. In view of the extremely close issue of liability —five physicians testified that the osteopath had done no wrong—the attorney's remarks constituted reversible error, the court concluded. The case was remanded for a new trial on all issues.—*Pierce v. Smith,* 301 So.2d 805 (Fla.Dist.Ct. of App., Sept. 27, 1974; rehearing denied, Nov. 6, 1974)

DEATHS

BIGGS, WILLIAM OTIS, Osyka. Born Grayson, La., Jan. 28, 1905; M.D., University of Louisville School of Medicine, Louisville, Ky., 1928; interned Central Hospital, Paducah, Ky., one year; died Feb. 8, 1975, age 70.

JOHNSON, LEE WHITE, Columbia. Born Columbia, Miss., Oct. 3, 1918; M.D., Tulane University School of Medicine, New Orleans, La., 1943; interned Touro Infirmary, New Orleans, La., one year; ob-gyn residency, same, March 1944-Sept. 1945; died Feb. 17, 1975, age 56.

KING, WILLIAM A., Rosedale. Born Greenwood, Miss., May 8, 1940; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1965; interned John Gaston Hospital, Memphis, Tenn., one year; died Feb. 11, 1975, age 34.

NEW MEMBERS

ABANGAN, ROLANDO T., Meridian. Born Ceba City, Philippines, June 29, 1938; M.D., Faculty of Medicine and Surgery, University of Santo Tomas, Manila, Philippines, 1961; interned Rochester General Hospital, New York, one year; general surgery residency, same, 1964-66; neurosurgery residency, University Medical Center, Jackson, Miss., 1966-71; elected by East Mississippi Medical Society.

AKERS, JOHN R., Meridian. Born West Point, Miss., Dec. 8, 1943; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1968; interned same, one year; anesthesiology residency, same, 1969-71; elected by East Mississippi Medical Society.

BOONE, GARY A., Meridian. Born Laurel, Miss., Feb. 13, 1940; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1965; interned Parkland Memorial Hospital, Dallas, Tex., one year; internal medicine residency, same, 1969-71; nephrology fellowship, University Medical Center, Jackson, Miss., 1971-73; elected by East Mississippi Medical Society.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension
Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
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Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

BRIGGS, FRANK R., Jackson. Born Jackson, Miss., Aug. 21, 1941; M.D., Medical College of Georgia, Augusta, Ga., 1967; interned University Medical Center, Jackson, Miss., one year; surgery residency, Medical College of Georgia, 1970-74; elected by Central Medical Society.

CLAY, JOHN C., Meridian. Born Meridian, Miss., Oct. 20, 1944; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1970; interned same, one year; internal medicine residency, same, 1971-73; hematology and oncology residency, same, 1973-74; elected by East Mississippi Medical Society.

FABIAN, JUDITH ANN, Pascagoula. Born Gulfport, Miss., Oct. 16, 1942; M.D., Tulane University School of Medicine, New Orleans, La., 1970; interned Charity Hospital, New Orleans, one year; anesthesiology residency, same, and Medical College of Virginia, Richmond, Va., 1971-74; elected by Singing River Medical Society.

GILLIS, WILFRED R., Jackson. Born Halifax, Nova Scotia, April 13, 1936; M.D., Dalhousie University Faculty of Medicine, Halifax, Nova Scotia, 1961; interned Victoria General Hospital, Nova Scotia, one year; elected by Central Medical Society.

GREER, THOMAS H., Meridian. Born Memphis, Tenn., May 25, 1940; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1966; interned Memorial Medical Center, Savannah, Ga., one year; internal medicine residency, University Medical Center, Jackson, Miss., 1970-73; elected by East Mississippi Medical Society.

HARRELL, REBECCA, Jackson. Born Tremont, Miss., Oct. 22, 1944; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1969; interned St. Joseph's Hospital, Houston, Tex., one year; radiology residency, University Medical Center, Jackson, Miss., 1970-73; elected by Central Medical Society.

HELLEMS, HARPER K., Jackson. Born Sinks Grove, W. Va., March 16, 1920; M.D., University of Virginia School of Medicine, Charlottesville, Va., 1943; interned Montreal General Hospital, Canada, one year; internal medicine residency, Peter Bent Brigham Hospital, Boston, Mass., 1946-50; research fellowships at W. Roxbury Veterans Hospital and Harvard Medical School; elected by Central Medical Society.

LYLE, RUSSELL R., Starkville. Born Senatobia, Miss., July 20, 1944; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1969; interned USAF Medical Center, Keesler Air Force Base, one year; pediatric residency, same, 1970-72; elected by Prairie Medical Society.

MCMULLAN, MARTIN H., Jackson. Born Newton, Miss., Nov. 26, 1940; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1966; interned same, one year; surgery residency, same, 1967-71; cardiovascular surgery residency, Mayo Clinic, Rochester, Minn., 1971-73; elected by Central Medical Society.

NICHOLLS, RICHARD A., Pascagoula. Born Norfolk, Va., Aug. 12, 1941; M.D., Medical College of Virginia, Richmond, Va., 1967; interned Charity Hospital, New Orleans, La., one year; ob-gyn residency, same, 1968-71; elected by Singing River Medical Society.

RAUSA, ALFIO, Greenwood. Born New York, N. Y., June 9, 1936; M.D., University of Bologna School of Medicine, Bologna, Italy, 1964; interned St. Michael Hospital, Newark, N. J., one year; elected by Delta Medical Society.

REID, MAY VIRGINIA, Jackson. Born New Orleans, La., Sept. 26, 1929; M.D., Tulane University School of Medicine, New Orleans, La., 1953; interned Philadelphia General Hospital, Philadelphia, Pa., one year; radiology residency, Ochsner Foundation Hospital, New Orleans, La., 1954-57; elected by Central Medical Society.

SEYLER, CLIFFORD A., Pascagoula. Born Jackson, Miss., May 16, 1945; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1971; interned same, one year; pediatric residency, Baylor College of Medicine, Houston, Tex., 1972-74; elected by Singing River Medical Society.

WADE, STANLEY A., JR., Meridian. Born Jasper, Ala., Jan. 4, 1946; M.D., University of Alabama Medical College, Birmingham, Ala., 1969; interned Lloyd Noland Hospital, Fairfield, Ala., one year; general surgery residency, same, one year; urology residency, University of Alabama Hospitals and Clinics, Birmingham, Ala., 1971-74; elected by East Mississippi Medical Society.

Book Reviews

Psychiatry in Primary Care. By Remi J. Cardoret, M.D., and Lucy J. King, M.D. 339 pages. St. Louis: The C. V. Mosby Co., 1974. $12.95.

This book, as the title states, is written for the primary physician, and the authors may have succeeded in doing for the subject of psychiatry what Guyton did for physiology with his textbook two decades ago.

The text, using the medical model approach, avoids the theoretical dynamic scheme with its often complex vocabulary and focuses on collections of signs, symptoms, and behaviors which, when taken together, are characteristic of a specific psychiatric syndrome.

The authors delineated some 13 such syndromes which cover the vast majority of patients with mental problems coming to the attention of the primary physician. The more commonly seen entities, such as the depressive syndrome, anxiety neurosis, hysteria, alcoholism, mental retardation, and organic brain syndromes are discussed in detail, and the less common conditions seen in general practice, such as the manic syndrome, obsessional and phobic neuroses, and schizophrenia are discussed in lesser but adequate detail.

Included in each chapter on the various psychiatric syndromes is a suggested plan of treatment which embraces current concepts on the use of psychotrophic drugs, as well as psychologically-oriented therapy. This is in addition to separate chapters devoted to the discussion of psychotherapy, drug treatment, and such specialized areas as EST.

Another section, quite valuable, deals with psychiatric emergencies, including acute psychoses, suicide attempts, violent behavior, and acute drug reactions.

Found in other sections of the book are suggestions on when to refer the patient to psychiatry for specialized help, along with a discussion of the referral process itself.

The text is highly recommended for the library of the primary care physician.

JAMES T. CHAMPION, M.D.
Meridian, Miss.

China Medicine as We Saw It. Edited by Joseph R. Quinn, Ph.D. 430 pages with illustrations. U. S. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health. DHEW Publication No. (NIH) 75-684, 1974.

This book is an anthology of reports by 16 physicians, nurses, and other medical scientists from the USA, Canada, England and Austria who visited China in 1972 and 1973. Included are descriptions of Chinese "innovations in health" such as the uses of acupuncture, limb reattachment and the integration of traditional Chinese with modern Western medicine. Public health organization and practice are described in considerable detail, and there are sections on cardiovascular diseases, nasopharyngeal cancer and schistosomiasis. Finally, achievements in applied microbiology are singled out for particular emphasis.

In the views of these observors there can be little doubt that the level of health care available to the Chinese has been enormously improved and expanded during the past quarter century. Some of the claims voiced in the book would appear to most Western physicians to be extravagant, such as "acupuncture of the ear is used especially in chronic ailments, including heart and liver ailments." It may also be noted that more than 12,000 cases of acute abdominal diseases that were treated by non-operative measures "resulted in a cure of more than 80 per cent of cases of acute appendicitis, over 90 per cent of acute pancreatitis and biliary ascariasis,"—"90 per cent of ectopic pregnancy," etc.

Electrical anesthesia and particularly acupuncture are emphasized as being suitable for the vast majority of surgical procedures. It is stated, however, that these forms of analgesia are frequently only partially complete and must often be supplemented. Many problems are recognized but some advantages are claimed.

In 1969 the medical school curriculum was reduced from 5 or 6 years to 3 years, due to the necessity of graduating more physicians. The statement is made that this reduction in time was made possible by the marked decrease or complete eradication of such diseases as syphilis, gonorrhea, scabies, etc.

with the result that it was no longer necessary to teach them in medical school! The point is also made that medical students are not required to take examinations but move directly into practice upon completion of 3 academic years of 10 months each.

All reports indicate that great emphasis is placed upon efficiency of operation. Hospitals are sparsely staffed and equipped with only the minimum of personnel and facilities. It is emphasized that the Chinese health care system does not promise all things to all people. Hospitals are considered to be educational institutions in the broadest sense and most have varying types of outreach programs. It is pointed out that China's health resources are not such as to permit "supporting for very long the chronically ill and disabled or the elderly when they are afflicted with serious disease." This would leave one to conclude that nursing homes and extended care units are few or non-existent and that the elderly must be cared for at home. It is also stated that Chinese hospitals do not have intensive care units or renal dialysis units and that little effort is devoted to "extending the lives of patients with uremia, cirrhosis, strokes, or cancer."

From these reports it would appear that the Chinese have made a major effort to bring at least some semblance of health care to all their people. Frequently, especially in rural areas, this would be considered primitive by Western standards. It would also appear that those individuals who receive the highest priority in the health care delivery system are those in the productive years of life and their children.

There are repeated references in the book to the fact that meaningful, reliable statistics and data on the effectiveness of the system are simply not available. Nevertheless, the authors appear unanimous in their conclusion that within the framework of the priorities established, truly impressive progress has been made.

T. J. Brooks, Jr., M.D.
Jackson, Miss.



Ralph E. Abraham has joined the staff of the Hattiesburg Clinic as a general and thoracic surgeon. Dr. Abraham is a graduate of the University of Mississippi School of Medicine and completed his surgical training at the University Medical Center.

T. J. Anderson, William M. Mayers, and C. T. Williams, Jr., of Laurel were on a recent program at the Laurel YWCA. They discussed what everyone should know in regard to their specific fields of medicine and answered questions from the audience.

Hal D. Bishop of Biloxi was inducted as a Fellow of the American Academy of Orthopedic Surgeons at the annual meeting in San Francisco.

John D. Bower of Jackson and UMC was presented "Mississippi's Physician of the Year" award by Governor Bill Waller. Dr. Bower was honored because of his pioneer work in developing a statewide system of supplying artificial kidney units.

Alfred W. Brann, Jr., of Jackson and UMC was guest speaker at the Feb. 9 Maternal and Infant Health Planning for Georgia meeting in Atlanta.

Curtis W. Caine of Jackson was guest speaker at the Cleary Sertoma Club's freedom banquet on Feb. 14. Dr. Caine discussed "Preserving the Basic Principles of Individual Freedom."

Carlos M. Chavez of Jackson and UMC attended the Pan-American Meeting of the Academy of Chest Physicians and Surgeons in Lima, Peru. Dr. Chavez is the U. S. representative of the American College of Chest Physicians to that academy.

Linda Chidester is now the full-time physician for the primary care program sponsored by the Appalachian Regional Commission in Tupelo. She is a graduate of the University of Tennessee and completed internship at St. Joseph's Hospital in Memphis.

John T. Copeland of Starkville announces the removal of his office to 1011 Evergreen Street.

Gene Crick, J. V. Ferguson, Jr., John Hey, S. G. Mounger, and Eugene Webb were elected to serve as advisors to the Delta Chapter of the Mississippi Association of Medical Assistants for 1975.

Barbara Goff of Jackson announces the opening of her office for the private practice of Psychiatry in Suite 605, Medical Towers, 440 E. Woodrow Wilson.

The Gulf Coast Symphony's 11th anniversary concert was dedicated to J. A. Graves of Biloxi. Dr. Graves was one of the symphony's founders and served as first president of the board of directors.

James D. Hardy of Jackson and UMC moderated a panel on electrolytes and gases at the Feb. 19 Southeastern Surgical Congress in Atlanta. Joseph C. Gabel of UMC served on the panel.

Mary Hawkins of Jackson announces the removal of her offices to 1037 N. Flowood. Her mailing address is P.O. Box 4902, Jackson 39216.

Henry E. Irby has set up offices at the Medical Clinic in Mize for general practice and general surgery. The clinic will be affiliated with Smith County General Hospital in Raleigh.

Michael E. Jabaley of Jackson and UMC participated in scientific sessions of the American Society for Surgery of the Hand in San Francisco.

Edley H. Jones, Chester W. Masterson, and John B. Ederington of Vicksburg announce the removal of their offices to The Eye-Ear-Nose and Throat Clinic, 1901 Mission 66.

Herbert G. Langford of Jackson and UMC presided over a sectional meeting during the Southern Society for Clinical Research convention in New Orleans.

Francis S. Morrison of Jackson and UMC presented a paper, "Immunology, Hematology and Oncology," at the Miss.-La. regional meeting of the American College of Physicians.

Edward R. North of Jackson was guest speaker for the Feb. 13 meeting of the Hattiesburg Association for Children with Learning Disabilities. Dr. North's topic was the importance of nutrition in therapy work.

J. W. Pressler of McComb announces the opening of his new clinic at 421 Marion Drive.

Roma Taylor of Verona has been named district health officer for Union County. Dr. Taylor also serves as acting district health officer for District III.

Virginia S. Tolbert of Ruleville has been nominated by McRae's Stores as one of the Beautiful Activists for 1975 in Mississippi.

David Ulmer of Columbus has been elected president of the Lowndes County Medical Society. He succeeds James Sams, outgoing president. Ledon Langston was elected vice president and John Parker, secretary-treasurer.

Joe Wayne Walker of Water Valley announces the removal of his office from the Spears' Clinic Building to the Medical Arts Building on Highway 7 South near Yalobusha General Hospital for the practice of internal medicine and cardiology.

Bill Wansley of Biloxi was crowned 1975 Revelers King of the 25th carnival ball held at the Broadwater Beach Hotel during Mardi Gras.

Gerald Wessler of Gulfport is serving as consultant to the newly organized Gulf Coast Kidney Foundation.

UMC Participates in Aspirin Study

The University of Mississippi Medical Center is one of 30 institutions nationwide participating in a National Heart and Lung Institute (NHLI) study to see if aspirin helps prevent recurring heart attacks.

The UMC phase of the five-year program is supported by a $340,000 NHLI contract. Principal investigator is Dr. Richard Hutchinson, assistant professor of medicine.

"Earlier research shows aspirin produces a profound impairment of the clotting action of blood platelets. Evidence also suggests that platelets may play an important role in the initial phase of myocardial infarction," Dr. Hutchinson said.

The UMC scientists hope to enroll 130 volunteers from the greater Jackson area who've had one or more heart attacks. In a double blind study half will get one tablet three times a day, the equivalent of three ordinary aspirins. The other half will take placebos.

"We want to stress that participants who enroll in the study must have the permission of their own physicians and will remain under their doctor's care," Dr. Hutchinson said.

Doctors who have patients who would like to volunteer should contact Dr. Hutchinson at the Medical Center, 2500 North State Street, Jackson, Miss. 39216.

Dr. Draper Will Head UMC Psychiatry Dept.

Dr. Edgar Draper has been appointed chairman of the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center.

Vice Chancellor Dr. Norman C. Nelson announced the appointment following action of the Board of Trustees of Institutions of Higher Learning.

Dr. Draper, whose appointment is effective July 1, 1975, succeeds Dr. Stewart Agras. Dr. James Suess, professor, will continue as acting chairman of the department until July.

Currently professor of psychiatry and professor in postgraduate education at the University of Michigan, Ann Arbor, Dr. Draper holds a B.D. degree from Garrett Biblical Institute, Evanston, Ill., and an M.D. degree from Washington University Medical School, St. Louis. He received the A.B. degree at Washington and attended Duke Divinity School, Durham, N. C.

Dr. Draper, a noted lecturer and panelist, is the author and co-author of several books, including *Psychiatry and Pastoral Care,* and has written scientific papers on graduate medical education, psychiatric training, the problem of suicide, the psychological function of religion, psychotherapy, and death and dying.

The former Peace Corps consultant is a diplomat of the American Board of Psychiatry and an examiner. He is also a member of the Society for the Scientific Study of Religion, the International Association for Suicide Prevention, a fellow of both the American Psychiatric Association and the American College of Psychiatry, and serves on the APA's task force on psychiatry and religion.

Dr. Draper was director of psychiatric resident education at the University of Michigan from 1968 to 1974 and was formerly associate professor at the University of Chicago, where he was co-director of the Psychiatry Outpatient Department.

He is a graduate of the Institute for Psychoanalysis, Chicago, Ill. The Missouri native interned at St. Louis City Hospital on the Washington University Service and did residencies at the University of Cincinnati, Cincinnati, Ohio.

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PSYCHIATRISTS:

James K. Ward, M.D.
F. Joseph Nuckols, M.D.
James A. Greene, M.D.
Charles W. Moorefield, M.D.
Otto F. Eisenhardt, M.D.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

6869 Fifth Avenue South
Birmingham, Alabama 35212

Sunday, May 4, Will Be "Arthritis Day" During the 107th MSMA Annual Session

The Mississippi State Medical Association has declared Sunday, May 4, 1975, to be designated "Arthritis Day" at the 107th Annual Session in Biloxi. This program, which will be chaired by Dr. Guy T. Vise, Jr., Medical Director and Chief Executive Officer of the new Mississippi Methodist Rehabilitation Center, will be aimed primarily toward the internist, pediatrician, family practitioner, and orthopedist who, as the primary care physicians, comprise the majority of the practicing medical profession within the state of Mississippi.

Recognizing the need for continuing education regarding recognition and treatment of arthritis and rheumatism, second only to heart disease as a leading chronic illness, four outstanding medical authorities have been invited as guest speakers for the Arthritis Day program. With Mississippi in its infancy regarding the arthritic victim, and with a need for a statewide program, the presentations by these four physicians will be of major educational value to the medical profession of the state.

Dr. William Donaldson of Pittsburgh, Pennsylvania, will speak on surgical management for the rheumatoid patient. Dr. Donaldson is President-elect of the American Academy of Orthopedic Surgeons.

Management of juvenile rheumatoid arthritis will be presented by Dr. Earl J. Brewer, Chief of Rheumatology Services at the Texas Children's Hospital in Houston, Texas.

Dr. Gene Hunder, Division of Rheumatology at the Mayo Clinic, will speak on differential diagnosis of rheumatoid arthritis.

Dr. Charley J. Smyth, Chairman of the Division of Rheumatology at the University of Colorado Medical Center, and Director of the Arthritis Treatment Center at General Rose Memorial Hospital, Denver, will present the medical management of the rheumatoid patient.

These talks will be of informative and educational interest to the physicians of the state and, at the conclusion of the presentations, a question and answer period, comprised of a panel of the four guest speakers and moderated by Dr. George W. Wharton, Associate Medical Director of the Methodist Rehabilitation Center, will be held for participation by the audience.

There are, at the present time, approximately 350,000 persons affected by this crippling disease in some form, representing 1 out of every 11 citizens within our state population. Early recognition and treatment can make a tremendous impact into the statewide cost of health care for this large group of afflicted persons.

The Arthritis Day program will be jointly sponsored by the Mississippi State Medical Association, the Mississippi Regional Medical Programs, the Mississippi Chapter of the Arthritis Foundation, the Mississippi Orthopaedic Society, and the Mississippi Methodist Rehabilitation Center.

Medical Center Sets Family Practice Review

The University of Mississippi Medical Center family practice review May 19-23 will help the state's primary care physicians prepare for the American Academy of Family Physicians board exams.

Thirty-two faculty members will target their presentations toward day-to-day family medicine, with emphasis on office practice.

Participants will discuss latest advances in such topics as coronary heart disease, hypertension, pediatric emergencies, and gynecology.

Course coordinator is Dr. Roland B. Robertson, assistant dean for continuing education, Schools of Medicine, Health Related Professions, and Dentistry, and director of the Division of Continuing Health Professional Education, which sponsors the event with partial support from Mississippi Regional Medical Program.

Enrollment fee for the five-day course is $150.00. Advance registration is required since the number of participants is limited.

Additional information can be obtained from the Division of Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, Miss. 39216.

ETV Produces Mental Health Series

"The Thin Edge," is a five-program series on educational television examining five universally-experienced psychological traits.

Produced by the WNET Science Program Group under a grant from Bristol-Myers Company, the programs will examine what science knows about each of the five conditions, what treatments are available and what can be done to avoid going over "the thin edge."

The five 60-minute color specials will be:

* "Depression: The Shadowed Valley." An examination of depression, that feeling of dejection that often accompanies loss, failure, frustration or lengthy illness. Causes of depression, symptoms, biological changes and modes of treatment will be examined.

* "Aggression: The Explosive Emotion." A timely study of aggression as both a healthy and an unhealthy emotion. The program will explain the sources of aggressive feelings and will examine some common myths about aggression.

* "Guilt: The Psychic Censor." An examination of guilt as a positive social force and a crippling mental problem. The program will include an explanation of Freud's theories of guilt and an evaluation of concepts designed to reduce feelings of guilt.

* "Anxiety: The Endless Crisis." A probe of anxiety, a mental problem that afflicts millions of Americans. Included in the program will be an examination of the physical consequences of anxiety and hints of coping with Twentieth Century American stress.

* "Sexuality: The Human Heritage." An examination of the explosive questions of sexual identity. The program will explore the history of sexual identity and will evaluate the effect current social and political movements will have on sexual identity issues.

"The Thin Edge" will air every other Saturday at 7 p.m., beginning April 5, over the Mississippi Educational Television Network (channels 19, Biloxi; 12, Booneville; 17, Bude; 23, Greenwood; 29, Jackson; 14, Meridian; 2, Mississippi State; and 18, Oxford-University).

MSMA Presents Check to SAMA President



Dr. J. T. Davis of Corinth, MSMA president, is pictured presenting a check for $250 to Alan J. Orkin, president of the Student American Medical Association, Mississippi Chapter. The state medical association yearly provides partial support for the SAMA officers to attend the national convention which is held in Chicago this year.

Preschool Program for Visually Impaired Set

The Board of Trustees of the Mississippi School for the Blind announces a preschool program for the visually impaired children of Mississippi. This program is designed to assist children, from birth to five years of age, and their parents.



Dr. Nelson

Services will be provided for the entire state of Mississippi, and will be funded by Title I ESEA.

The primary objective is to locate and prepare potentially eligible visually impaired children for entry into school, and to orient parents on educational processes for their child.

Members of the Board of MSB are: Dr. Norman C. Nelson, Vice Chancellor and Dean, University Medical Center; Dr. G. M. McClendon, president emeritus of Hinds Junior College (chairman of the board); Dr. Garvin H. Johnston, state superintendent of education; John Niles, accountant with Montfort-Jones Hospital in Kosciusko; Charles Reed, Jr., parent of visually impaired students; J. I. Rankin, retired director of the Mississippi Rehabilitation Division for the Blind; J. W. Roberts, banker; Mrs. C. S. Weir, parent of deaf child; and William Williamson, Greenville optometrist.

For further information, please contact the Mississippi School for the Blind, 1252 Eastover Drive, Jackson, Miss. 39211.

Physicians' Wives Work With 1975 Arts Festival

Wives of Mississippi physicians are prominent among the chairmen preparing for the 1975 Mississippi Arts Festival, opening its gates for the twelfth consecutive year April 23-27. Serving on the Executive Committee are Mrs. James Hays and Mrs. E. Leonard Posey, III.

A feature presentation of the 1975 festival is the re-creation of the Mississippi Folklife Exhibition originally compiled by the Smithsonian for presentation on the Washington Mall last July. This celebration of Mississippi's rich folk heritage will feature musicians and craftsmen ranging from fiddlers, spiritual groups, and a one-string guitarist to blacksmiths, saddle makers, and freehand stitchery artists. The folk life emphasis will culminate Friday evening in "Down Home Night," planned as a family event featuring a potpourri of the best folk life talent and a catfish and hushpuppy fry. On Saturday afternoon the wares of the folk artisans, such as double weave baskets and hand-tooled chairs, will be auctioned, and Sunday will feature an old-fashioned fiddling contest.

A series of seminars as designed to enhance the folk life features. On Thursday Mississippian Bill Ferris, nationally acclaimed folklife expert currently teaching at Yale, will lead a seminar on folklore in Mississippi. On Friday and Saturday, nationally recognized experts will present a Faulkner Seminar at the R&D Center. The author of *Historic Architecture in Mississippi,* Mary Wallace Crocker, will lead a Wednesday seminar; this volume is one of three university press publications selected for review on the *Today* show recently.

Opening festival week will be a series of cooking demonstrations planned by Jackson physicians' wives, Mrs. Clarence Webb and Mrs. James Keeton. At the demonstrations John Clancy, the executive chef of the well known Time-Life *Foods of the World* cookbook series, will offer four cooking lessons in international cuisine.



Among doctors' wives working on the 1975 festival are from left, seated: Mrs. James Keeton (Cooking Seminar), Mrs. Tate Thigpen (Literary Competition), and Mrs. James Hays (Festival Treasurer). Standing are Mrs. Clarence Webb (Cooking Seminar), Mrs. Julian Henderson (Picnic Facilities), Mrs. Mart McMullan (Speakers Bureau), Mrs. Richard Blount (Symphony Youth Concerts), Mrs. Ancil Tipton (Magazine Pomotion), Mrs. E. Leonard Posey, III (Festival Promotion), and Mrs. Ed Levine (Program Distribution).

The Mississippi Art Association exhibit will feature the works of John Chumley, who celebrates the people and landscapes of his home in the Shenandoah Valley. The surface simplicity of his work within this realistic genre belies the fact that they are enormously complex creations in water color and egg tempera.

A special presentation in the MAA Building is the debut of *Theora Hamblett Paintings,* a book published by our University Press and offered for this occasion in a limited edition of leather bound copies. The 64th annual Mississippi Artists Competitive Exhibition and the Mississippi Collegiate Exhibition, both juried by John Bullard of the New Orleans Museum of Art, will also be in the building. At the Municipal Art Gallery throughout the week Bill Dunlap and the Famous Four, members of the faculty of Appalachian State University at Boone, N. C., will be showing and lecturing.

The preparations always made for young festival-goers are especially enticing this year. The Children's Pavilion, reflecting the folk life emphasis of the festival, is entitled "Mississippi in Legend," and invites the children to ride with Casey Jones, walk through an Indian village, climb Fort Mississippi, and float down the river. Storytelling, children's art, a children's TV workshop, and youth concerts all beckon between performances of such children's plays as the *Mickey Mouse Jamboree-Musical Special, Alice in Wonderland,* and *Winnie the Pooh.* A Friday production of *Godspell* is sure to attract many adults to the Children's Playhouse.

Live evening performances will offer exciting variety and top names. On April 24 an evening of ballet will feature Ivan Nagy and Natalia Makarova, a favorite of Western audiences since she defected from the Soviet Union in 1970. For theatre fans New Stage will present "Geraldine Fitzgerald in Concert"—a one-woman revue by the heralded actress.

In the Coliseum Friday night an exciting twin bill of popular stars will feature singer Bobby Vinton, presently taping a new TV series, and Maureen McGovern, whose recordings of "The Morning After," and "We May Never Love Like This Again" have been top hits this year. The Coliseum Saturday show features another fine twin bill. Leading the evening will be Ferrante and Teicher, the renowned piano duo, classically trained but best known for their rendition of movie themes such as "The Apartment." Following intermission the audience will greet Pearlie Mae herself—the fabulous Pearl Bailey. Preceded by a witty drum solo by her husband, Louis Bellson, Miss Bailey will present an exercise in the old style one-woman show, backed by a 26-piece orchestra.

For ticket information, write Mississippi Arts Festival, Box 4354, Jackson, Miss.

Tri-State Thoracic Conference Held



The 1975 Annual Tri-State Thoracic Case Conference, sponsored by Lung Associations and Thoracic Societies of Mississippi, Alabama, and Louisiana, was held in Biloxi in mid-January. Program participants from the Mississippi Thoracic Society were (from left) Dr. Roland B. Robertson, Jr., Dr. Guy Campbell, both of Jackson, and Dr. John R. Williams, of Greenville, president of MTS. Other Mississippi physicians (not pictured) who participated in the annual two-day event for respiratory specialists include: Dr. Bernard H. Booth, Dr. G. Boyd Shaw, and Dr. Walter Treadwell, secretary, all of Jackson.

Medical Center Has New Faculty Members

Six faculty appointments have been announced at the University of Mississippi School of Medicine at the Medical Center.

Vice Chancellor Dr. Norman C. Nelson announced the appointments following action of the Board of Trustees, Institutions of Higher Learning.

Clinical instructor in radiology since May 1974,

Dr. William Frazier Russell has joined the full-time faculty as assistant professor of radiology.

Dr. Fred J. Oelshlegel, Jr., is assistant professor of preventive medicine, and Dr. Shahla Kabir is an instructor in obstetrics and gynecology.

Dr. Oelshlegel, whose appointment is effective July 1, 1975, is currently a senior research associate at the University of Michigan Medical School, Ann Arbor, Mich. He has been at Michigan since 1970, first as an NIH research fellow and then as a research associate.

Formerly a chemist with Eastern Regional Research Laboratories, Philadelphia, Pa., Dr. Oelshlegel got the B.S. degree at Drexel University, Philadelphia, Pa., and the Ph.D. degree from the University of Wisconsin, Madison.

Dr. Kabir joined the UMC faculty in early January. Before taking her present post, the Bangladesh native was associate professor of obstetrics and gynecology at the Institute of Postgraduate Medicine and Research, Dacca, Bangladesh.

She holds the Intermediate of Science degree from M. C. College, Sylhet, Bangladesh; the M.B.B.S. degree from Dacca Medical College, Dacca, Bangladesh; and the M.R.C.O.G. degree from Royal College of Obstetricians and Gynecologists, London, England.

Dr. Kabir has held appointments at Dacca Medical College Hospital; Royal Infirmary, Glasgow, Scotland; Bradford Royal Infirmary, Yorkshire, England; Lewisham General Hospital, London, England; and Sadar Hospital, Khulna, Bangladesh.

Dr. Kenneth Wayne Olsen, whose appointment is effective in August, will be an assistant professor of biochemistry. Currently a postdoctoral fellow at Purdue University, West Lafayette, Ind., he holds the B.S. degree from Iowa State University, Ames, Iowa, and the Ph.D. degree from Duke University, Durham, N. C.

Lloyd B. Gallimore, Jr., and Dr. John Howard Romfh will come to the Medical Center July 1 as instructors in anatomy. Dr. Lawrence S. Goldstein joins the faculty in July as an instructor in obstetrics and gynecology.

Gallimore, an instructor at Bowman Gray School of Medicine, Winston-Salem, N. C., is a May candidate for the Ph.D. degree from Bowman Gray. He received the B.S.C.E. degree from North Carolina State College, Raleigh, N. C., attended Wake Forest University at Winston-Salem, and got the M.S. degree from Bowman Gray in 1973.

Dr. Romfh is an instructor at the University of Alabama at Birmingham, where he earned the Ph.D. degree in 1974. He holds B.A. and M.A. degrees from Florida Atlantic University, Boca Raton.

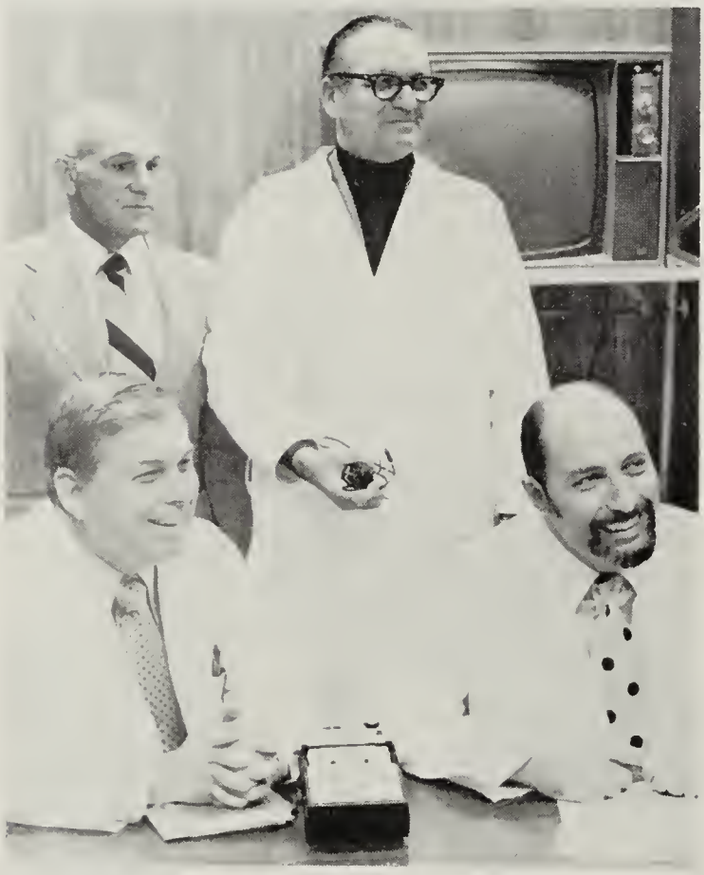
Dr. Goldstein is a 1972 University of Mississippi School of Medicine graduate who will complete obgyn residency requirements at University Hospital in June. He earned the B.S. degree from Delta State University.

Medical Center Holds ENT Course



Family physicians reviewed the basics of otolaryngology in a University of Mississippi Medical Center one-week intensive course in ENT. Participants included, from left, seated, Dr. Robert E. Coghlan of Aberdeen, Dr. J. H. Shoemaker of Okolona, and, standing, Dr. John Estess of Hollandale and Dr. Charles H. Allen, Jr., of Moss Point. Mississippi Regional Medical Program gave partial support to the UMC Division of Continuing Health Professional Education sponsored course.

Physicians Take ENT Course



Participants in the one-week intensive course in otolaryngology at the University of Mississippi Medical Center included, from left, seated, Dr. James Waites and Dr. Charles A. Hollingshead, both of Laurel, and, standing, Dr. E. J. Schmidt of Bude and Dr. Lloyd Z. Broadus of Purvis. The UMC Division of Continuing Health Professional Education sponsored the course with partial support from Mississippi Regional Medical Program.

Cancer Control Conference Set

The 2nd Spring Conference on Cancer Control, sponsored by the Nevada Tumor Registry—Nevada Cancer Control Institute, will be held in Las Vegas, Nev. on April 10 and 11, 1975 at the Sahara Hotel.

Recent advances in the treatment of malignant melanoma, lymphoma and multiple myeloma will be discussed.

For information write Ms. Irene S. Peacock, 1800 W. Charleston Blvd., Las Vegas, Nev. 89102.

Emergency Medicine Studied in Atlanta

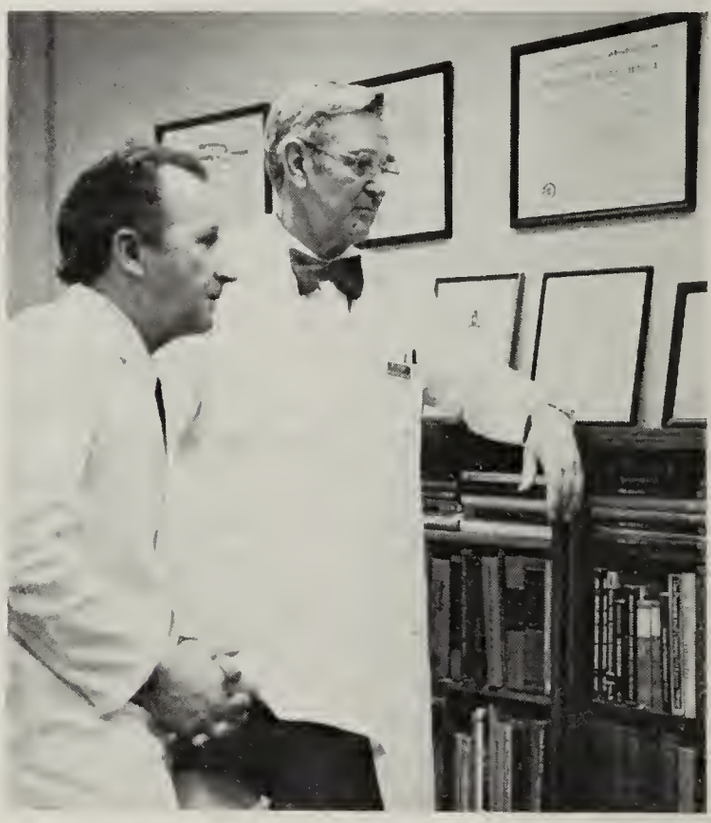
A scientific assembly on Emergency Medicine will be presented April 21-23 at the Fairmont Colony Square Hotel in Atlanta.

Sponsoring organizations are Georgia Chapter, American College of Emergency Physicians; School of Medicine, Medical College of Georgia; and Emergency Department Nurses Association.

Fee is $115 for ACEP member; $140 for nonmember physician; and $55 for EDNA member.

For more information write Dr. L. M. Haddad, Emergency Department, Memorial Medical Center, Savannah, Ga. 31405.

Goldberger Lecturer Featured at UMC



Dr. George V. Mann, left, a Vanderbilt University professor and internationally noted authority on the absence of heart disease in some primitive peoples, was the University Medical Center's first Joseph Goldberger Lecturer in Nutrition. In a student/faculty assembly he discussed inaccessible, accessible, and uncertain risk factors in heart disease and said, "Much of what we've believed for 20 years about heart disease is being proven untrue." The UMC Department of Preventive Medicine, whose chairman is Dr. Thomas J. Brooks, Jr., right, hosted the Goldberger Lecturer sponsored by the American Medical Association.

Family Physicians Take UMC Course



Primary care physicians who studied the latest concepts in diagnosing and treating common urologic diseases at the University of Mississippi Medical Center included, from left, Dr. W. B. Larkin, Jr., of Bude, Dr. Frank Wade of Magee, Dr. Robert L. Thompson of Laurel, and Dr. James L. Thornton of New Albany. Dr. L. H. Brandon of Starkville also participated in the one-week intensive course, sponsored by the UMC Division of Continuing Health Professional Education with partial support from Mississippi Regional Program.

Chest Physicians Call for Abstracts

A "Call for Abstracts" has been announced by the American College of Chest Physicians. The program committee for the 41st Annual Scientific Assembly invites submission of abstracts in the disciplines of circulation, respiration, thoracic/cardiovascular surgery and related systems. Accepted abstracts will form the basis for presentations at the college's annual meeting to be held in Anahcim, Oct. 26-30, 1975.

A mandatory requirement is that the material submitted will not be published or presented elsewhere prior to Oct. 30, 1975. Membership in the college is not a prercquisitc to participation in the program.

Accepted abstracts (200 words maximum) will be published in *Chest,* thc official journal of the American College of Chest Physicians. Presentations at the Scientific Assembly will be limited to 10 minutes, with an additional two minutes for discussion.

Deadline for submitting abstracts is May 15, 1975. All applicants will be notified of the decision of the Scientific Program Committee within six weeks after the deadline.

Submission of abstracts, as well as inquiries on details of requirements, should be directed to Dr. W. Gerald Rainer, Chairman, Scientific Program Committee, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Ill. 60068.

State Pharmacists Have New Publication



Mrs. Jo Suber of Oxford, executive secretary of the Mississippi State Pharmacentical Association, looks over Vol. 1, No. 1 of the association's new publication, "Mississippi Pharmacist," with contributing author Dr. Dewey D. Garner, associate professor of Health Care Administration at the University of Mississippi.

dating of the "health voting index" on each member of the 1972-75 Mississippi Legislature. The latter will become an important part of the Mississippi Medical Political Action Committee's (MPAC) local candidate support program to be conducted during this year's legislative races.

The association had a five-point legislative program for the 1975 Regular Session dealing with the following subjects: (1) Health Maintenance Organizations; (2) physician assistants; (3) a 28-day life span for CPD preserved blood; (4) mental hospital commitment procedures; and (5) upgrading of professional fees authorized under the Mississippi Medicaid Program. The association actively supported or opposed other legislative proposals before the 1975 Legislature. A full report will be made in this regard at the annual session.

Mississippi Foundation for Medical Care, Inc.—Based on directives from the House of Delegates, the MFMC sought and obtained funding as the "conditional PSRO" for Mississippi during the past year. Much work and planning by many Mississippi physicians preceded the Foundation/PSRO going operational the early part of 1975. Work has also proceeded on plans to establish a peer review program with all third party payors. Foundation membership increased during the past year and now totals 1,100 physicians. In October 1974 a mail ballot election of the MFMC Board was conducted by the membership.

The MFMC will hold an annual membership meeting in conjunction with the 107th Annual Session.

Experimental Medical Care Review Organization (EMCRO)—The association's EMCRO project, directed at developing a physician-sponsored system for evaluating the quality of medical care, has been phased into the activities of the Mississippi Foundation for Medical Care PSRO Program. The EMCRO project which was funded initially in 1971 has served as a valuable research and development resource for the PSRO Program. Dr. Millard S. Costilow, principal investigator for the MSMA/EMCRO Program, serves as a director of the Mississippi Foundation for Medical Care.

Journal MSMA—The JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION concluded its 15th year of continuous publication in 1974. The thrust of the JOURNAL continues solidly around Mississippi medicine and the JOURNAL serves as the association's prime communication mechanism with the membership.

Total pages in Volume XV, 1974, were down from 1973 reflecting fewer national ads and our efforts to produce a smaller book for economical reasons. Local advertising continued to increase and a concerted effort is being made to continue this trend. Editorials and news about Mississippi medical activities were kept at their 1973 content levels.

Among other services the JOURNAL provides the membership are: complete program of the annual sessions; handbook and proceedings of the House of Delegates; and regular listing of component medical society officers and meeting dates.

The Board wishes to acknowledge special appreciation to the editors and Committee on Publications in the production of this vital membership service.

Mississippi Medical Political Action Committee (MPAC)—MPAC conducted its most successful membership recruitment drive during this past year and was officially recognized by the American Medical Political Action Committee for its efforts in this regard. A new monthly newsletter for all MPAC members called "MPAC Reports" was initiated during the year. The newsletter concentrates on the state and national political scene.

Based upon their past voting records and excellent support of organized medicine, MPAC elected to support those incumbent Mississippi congressmen who had more than token opposition in last fall's general elections. Each candidate was overwhelmingly reelected to office.

At the 106th Annual Session, the House of Delegates directed the organization and support of local candidate support committees in the 1975 Mississippi Legislative elections. MPAC is proceeding to organize this endeavor and a report will be made in this regard at the annual session.

Organization of the Board—Two new trustees, Drs. Joe S. Covington of Meridian, District 6, and Arthur A. Derrick of Durant, District 4, were welcomed to the Board during 1974-75. Officers of the Board during the year were Drs. James O. Gilmore, Oxford, Chairman; Everett Crawford, Tylertown, Vice Chairman; and Gerald P. Gable, Hattiesburg, Secretary.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

The following amendments to the MSMA Constitution and By-Laws were presented in open session at the 106th Annual Session and officially sent to each component society two months prior to the

107th Annual Session as required by Article XII MSMA Constitution which states:

"The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been sent officially to each component society at least two months before the session at which final action is taken."

The proposed amendments would result in the following if adopted:

1. Provide that nominees for election of office attend one of past two or current annual sessions;
2. Provide for election of two trustees to the Board of Trustees from association District 5;
3. Provide that the president and immediate-past president shall be members of the Board of Trustees;
4. Provide that trustees and council members shall serve no more than two consecutive three year terms;
5. Provide that no member shall be eligible for election as a trustee who has served in that office two consecutive three year terms within the past six years;
6. Provide that no member shall be eligible for election to a council who has served on that council two consecutive three year terms within the past six years;

Amend Article VI—MSMA Constitution—General Officers—Section 3. ". . . The officers of this association shall be elected by the House of Delegates on the last day of the annual session following the adjournment of the general meeting, but no person shall be elected to any such office who has failed to attend *one of the past two or current annual sessions* and who has not been a member for the past two years."

Amend Article IX—MSMA Constitution—Board of Trustees. ". . . The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates and shall perform such duties as are prescribed by law governing directors of corporations and in the By-Laws of the Association. The Board shall consist of *12* members, one from each of the nine association districts *except association District V which is authorized two members,* elected for terms *of three* years each *and the president and immediate-past president.* A trustee shall not serve more than *two* consecutive terms *and no member shall be eligible for election to the Board of Trustees who has served on the Board two consecutive terms within the past six years.*"

Amend Chapter VIII—MSMA By-Laws—Board of Trustees—Section 1. ". . . The Board of Trustees shall be the executive and governing body of the association during vacation of the House of Delegates. It shall consist of *12* members, one from each association district *except association District V which is authorized two members,* whose terms of office shall be three years. A trustee shall not serve more than *two* consecutive terms. *No member shall be eligible for election to the Board of Trustees who has served on the Board two consecutive terms within the past six years. The president and immediate-past president of the association shall also serve on the Board of Trustees.* During vacation, the Board of Trustees shall exercise the powers conferred upon the House of Delegates by the Constitution and these By-Laws, provided that in the exercise of these powers thus conferred, the Board of Trustees shall neither consider nor act to contravene any action, mandate, or policy of the House of Delegates which may still be in effect."

Amend Chapter IX—MSMA By-Laws—Councils—Section 1. ". . . Councils of the association shall be elected standing bodies of the House of Delegates, responsible thereto. There shall be a Council on Medical Service, a Council on Scientific Assembly, a Judicial Council, a Council on Constitution and By-Laws, a Council on Legislation, a Council on Budget and Finance, an Editorial Council, and a Council on Medical Education. A council member shall not serve more than *two* consecutive terms. *No member shall be eligible for election to a council on which he or she has served two consecutive terms within the past six years.*"

RECOMMENDATIONS OF COMMITTEE TO STUDY COMPONENT MEDICAL SOCIETIES AND COMPENSATION OF ELECTED MSMA OFFICERS

Background. At the 106th Annual Session, the House of Delegates adopted recommendations that a committee of the House be appointed to study: (1) methods of strengthening personal communication between the state and component societies; (2) compensation of elected officers of the association; and (3) methods of strengthening the component

society as an organizational entity of the association. Subsequently, the president appointed a committee to include the chairmen of the Councils on Scientific Assembly and Medical Education, several of the component medical socicty secretaries, and Dr. Arthur A. Derrick of Durant as chairman.

Recommendations of the Committee. The committee met on Oct. 10, 1974, and arrived at the following recommendations, the first six of which have been forwarded to the presidents and secretaries of the component societies for their review and comment:

Recommendation No. 1—That MSMA conduct an annual orientation program for all component society officers, preferably in conjunction with the MSMA annual session. The committee feels that such a "workshop" or orientation program would better prepare all society officers for the conduct of their duties. The program would consist of such subjects as the relationship between component societies, MSMA and the AMA, parliamentary procedure and conducting meetings, services available to component societies, the responsibilities of component societies in the framework of organized medicine, the duties of officers, the organization of scientific programs, etc.

Recommendation No. 2—That the MSMA coordinate and cooperate with the component societies in arranging meetings or programs that would offer continuing medical education accreditation for those in attendance. The committee feels that a society program that provides CME accreditation would greatly enhance member attendance and interest.

Rccommendation No. 3—That MSMA establish a "speaker's bureau" composed of authorities on such matters as practice management, business investments, malpractice, politics, taxation, etc., and that these speakers be made available to component societies upon request to present a program. Needless to say, the committee feels that the availability of such speakers to any component society upon request would enhance attendance and offer a valuable service to its members. The committee further feels that any expenses necessary to retain such speakers should be borne by MSMA and not the societies.

Recommendation No. 4—That MSMA provide clerical services to any component society that requests them. The committee is well aware of the fact that only one of the 18 component societies has a staff to provide administrative and clerical services. Consequently, component society officers are often forced to rely on their already overworked office personnel to provide secretarial and clerical services for the society. In view of this fact, the committee encourages each component society to call on the MSMA staff to provide clerical or administrative services whenever they are needed.

Recommendation No. 5—That MSMA provide all component society officers with a complete summary of actions by the House of Delegates following each annual session. The committee feels that it is very important for the component societies, and especially their officers, to be well informed about the activities of the association's policymaking body, and that such information is important to an officer in the conduct of his official duties.

Recommendation No. 6—That each component society hold an annual "legislative night" and invite all legislators in the society area to the meeting. The 1974 House of Delegates also recommended that each society conduct a "legislative night" for the purpose of discussing voting records and health care issues with their legislators. The committee strongly feels that such an activity would not only provide an interesting and informative program, but would greatly assist the medical profession's efforts in assuring the passage of sound and constructive health legislation.

Recommendation No. 7—That in accordance with Section 6, MSMA By-Laws, each MSMA trustee give an annual report at the winter meeting of the Board concerning his visits to the component societies within his respective association district in his capacity as the ". . . organizer and arbiter for the Association district. . . ."

Recommendation No. 8—That the president, president-elect, vice presidents, and secretary-treasurer be reimbursed for travel expenses incurred in visiting the association's component societies.

Recommendation No. 9—That the president's "honorarium" be increased from $1,000 to $1,500.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Organization and Duties—The Council on Medical Service is a constitutional body of the House of Delegates, consisting of nine members, one from

each association district, elected for terms of three years each. The council is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under the council's jurisdiction are assigned activities of the association in medical service, emergency service programs, medical care for the indigent, and the work of allied medical agencies and organizations.

The council is assisted by several committees. These embrace a range of subject areas to include maternal and child care, blood and blood banking, mental health, and nursing.

Committee on Nursing—The Committee on Nursing serves as the association's liaison committee with a similar committee of the Mississippi Nurses Association. The committee is working to implement the expanded role for the RN as directed by the House of Delegates and authorized by statute. The MSMA-MNA Joint Practice Committee is serving in a consulting role to the Mississippi State Board of Health and Board of Nursing in developing standards and administrative procedures for the expanded role of the nurse. The committee notes the several programs available to the RN and leading to an expanded clinical role in health care delivery. The committee and council believe it should be stressed that in an expanded clinical role, the RN should function under supervision of a physician(s) and never function in an independent medical practice role.

Committee on Mental Health—The Committee on Mental Health met during the year to consider the organization of the new State Department of Mental Health as created by the 1974 Legislature and the House of Delegates directive that the association support legislation to modernize our current mental institution commitment laws. The committee has expressed concern that a non-M.D. director could be appointed to replace the current physician-director of the Department of Mental Health if he resigns. The director is appointed by the Board of the department. Legislation to modernize the state's commitment laws and to make the laws conform to recent judicial decisions was considered by the 1975 Mississippi Legislature. This legislation will be reviewed in other reports and the council recommends that pertinent portions of the legislation be brought to the attention of all Mississippi physicians.

Committee on Maternal and Child Care—The Committee on Maternal and Child Care continues its study of maternal deaths in Mississippi. During the year the committee completed study of all cases occurring in 1972 and a report on this has been prepared for publication in the JOURNAL MSMA. The committee's "Maternal Health Desk Cards," which serve as a handy reference source on maternity care, have been revised, published in a new format, and distributed to all hospitals in the state.

Other Council Activities—The council has considered other subject matter within its sphere of assigned interest and will present a supplemental report to the House of Delegates in this regard at the annual session.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Organization and Duties—The Council on Scientific Assembly is a constitutional body of the House of Delegates charged with the responsibility of planning the annual session of the association to include all scientific activities, programming, and the scheduling of annual session events. The council membership consists of the chairmen and secretaries of the eight scientific sections and the secretary-treasurer of the association, a total of 17 members.

107th Annual Session—Planning and organization of the 107th Annual Session was initiated in the summer of 1974. The format has been changed this year to condense the meeting. *The final session of the House of Delegates will meet on Thursday morning rather than Thursday afternoon. To facilitate this, several of the eight scientific sections will be meeting simultaneously.* The schedule was also arranged so that there would be one afternoon completely free of planned activity, Wednesday, May 7. To the extent possible, conflicts in schedules and programming have been eliminated, although as a practical matter, such total elimination is not possible. In some instances, the council has requested and placed essayists from various specialty societies not represented in the Scientific Assembly before section audiences.

We are gratified that at the present annual session, 15 specialty societies have related or concurrent meetings with us. Four medical alumni groups have fraternal and social occasions, and various nonscientific but medically related bodies will meet during May 5-8. Added attractions this year include a Sunday afternoon program, "Arthritis Day," which is sponsored by the Mississippi Methodist Rehabilitation Center, the Arthritis Foundation, and the Mississippi Regional Medical Program. The Mississippi Sports Medicine Society will hold its organizational meeting and host a guest speaker during convention week. We continue to believe that providing for and encouraging these related meetings increases the attractiveness of the annual session to the membership

and benefits attendance. We are glad to continue support of the Woman's Auxiliary concurrent annual session. The auxiliary will again host the hospitality booth on Sunday afternoon to greet and welcome convention goers.

Scientific and Technical Exhibits—Your council is grateful for the participation of our scientific and technical exhibitors in this 107th Annual Session of the association. Presentations in the scientific exhibit number over 20 this year. We urge every member and guest to view these educational exhibits and the technical exhibits.

Headquarters Hotel—The annual session will be held at the Sheraton-Biloxi for the fifth year. In 1976 the convention will return to Jackson and the headquarters hotel will be the new Holiday Inn Downtown.

The council is directing an extensive promotional campaign through the JOURNAL MSMA and the Blue Sheet to increase attendance at the annual meeting. The format and size of the annual session hand program is also being revised.

Expression of the Council—Your Council on Scientific Assembly is grateful for the support, cooperation, and assistance we have received in planning the 107th Annual Session of the association.

Emergency Medicine Assembly Slated

The Pennsylvania Chapter of the American College of Emergency Physicians and Emergency Department Nurses Association will be presenting the Fourth Annual Science Assembly, April 23-26, 1975, at the New Hilton of Philadelphia, Civic Center Blvd. at 34th Street, University of Pennsylvania Campus.

Medical Education Credits have been approved for 22 hours by American College of Emergency Physicians and the American Medical Association.

For further information, contact R. M. Celmer, R.N. at 2513 Brown Street, Philadelphia, Penn. 19130.

UMC Features Visiting Professors



Dr. Jeanette Pullen, left, assistant professor of pediatrics at the University of Mississippi School of Medicine, and other Medical Center faculty and students talked with Dr. Marion Barnhart, second left, and Dr. Jeanne M. Lusher, right, before their presentation on sickle cell anemia at the regular UMC Center Assembly. Dr. Barnhart is professor of physiology at Wayne State University, Detroit, Mich., and director of Bargman Foundation for Cell and Molecular Research. Dr. Lusher is associate professor of pediatrics at Wayne State and director of the Department of Pediatric Hematology-Oncology at Children's Hospital of Michigan, Detroit Medical Center.

Southwest Allergy Forum Scheduled

The Southwest Allergy Forum will be held in Houston, Tex., at the Houston Oaks Hotel on May 11-13, 1975.

For further information contact Dr. Warren J. Raymer, General Chairman, 444 Hermann Professional Building, Houston, Tex. 77025.

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

MAY 1975

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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ORIGINAL PAPERS

Near-Drowning: A Complex Pathophysiologic Injury

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Near-drowning produces pathophysiologic changes that are secondary to aspiration pneumonia, adult respiratory distress syndrome, profound hypoxemia, and metabolic acidosis. Patients should be closely monitored with frequent arterial blood gases, acid-base determinations and chest x-rays. The authors present an illustrative case and discuss their management of the patient.

EACH YEAR 140,000 persons drown, 7,000-8,000 in the USA.[1] This is the third highest cause of accidental death in children and the fourth highest in all age groups. Most of these drownings occur during boating or swimming. The actual number of near-drownings is unknown since these are not routinely reported. A recent case which we managed is reported here.

CASE REPORT

A 15-year-old boy was found lying on the bottom of a local swimming pool. He had made several laps underwater before his friends noticed that he was still. Artificial respiration was instituted at the poolside before transfer to the Mississippi Baptist Hospital Emergency Room.

On admission to the Emergency Room, he was obviously cyanotic. Also, he was noted to be in marked respiratory distress and was having hemoptysis. Physical examination revealed diffuse rales in both lungs. He had a sinus tachycardia with a ventricular rate of 120 beats per minute.

Initial arterial blood gas determinations on 6 liters of oxygen by nasal biprong showed a PaO_2 48, $PaCO_2$ 37, pH 7.30. He was immediately intubated and placed on a Bird respirator while en route to the Intensive Care Unit. There, he was transferred to a MA-1 volume ventilator which was adjusted to 100 per cent F_IO_2 (per cent inspired oxygen) and 10 cm. PEEP (positive end expiratory pressure) to achieve a PaO_2 77, $PaCO_2$ 36, pH 7.33. His initial blood chemistries were normal, except for serum calcium 8.5 mg/100 ml and potassium 2.8 mEq/L. His initial serum osmolarity was 274 mOsm. The electrocardiogram was normal other than a tachycardia. The chest x-ray was consistent with pulmonary edema (see Figure 1).

Methylprednisolone, 500 mg, was given intravenously and continued at 250 mg every four hours for the first 24 hours. He was also given 600,000 units of aqueous penicillin every six hours. The patient's pulmonary status, as measured by arterial blood gases, gradually improved, and his F_IO_2 and PEEP were reduced accordingly. He was extubated after 48 hours. The steroids and penicillin were

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gradually discontinued over the next 48-72 hours. By this time his chest x-ray had shown some clearing. Six days after admission, the patient's room air blood gases revealed a PaO_2 89, $PaCO_2$ 35, pH 7.44. He was discharged after eight days of hospitalization with a normal chest x-ray (see Figure 2).

One month after discharge, pulmonary function studies and arterial blood gases were interpreted as normal. His only complaint was a mild cough, which was improving. This near-drowning victim has returned to all his previous sports activities.

DISCUSSION

Causes. Craig[2] documented hypoxia occurring after hyperventilation as the probable cause of loss of consciousness during underwater swimming. He noted that swimming underwater is, in fact, breath-holding during exercise. Using volunteers he demonstrated their end tidal oxygen tension (P_AO_2) to be as low as 43 mm Hg when the breath was held during exercise and after hyperventilation. The end tidal carbon dioxide tension (P_ACO_2) did not attain values that would elicit symptoms due to hypercapnia. The end tidal P_AO_2 decreased rapidly after prolonged hyperventilation resulting in apnea, but the P_ACO_2 did not rise as quickly, which could lead to unconsciousness before the hypercapneic drive to breathe was reached. Therefore, physicians should educate their patients regarding the hazards of hyperventilation prior to underwater swimming. Of course, in any drowning accident other causes such as drug and alcohol intake, neck and spinal injuries, seizure disorders, and, in older victims, myocardial infarction and cerebrovascular accidents must be carefully considered.

Near-Drowning Without Aspiration. Laryngospasm may produce acute airway obstruction without aspiration. If resuscitation is successful, these individuals generally recover rapidly. However, prolonged asphyxia with a 10-15 per cent mortality can result from severe laryngospasm, when only minimal amounts of water have entered the lungs.

Near-Drowning With Aspiration. Differences in fresh water and sea water aspiration are due to the

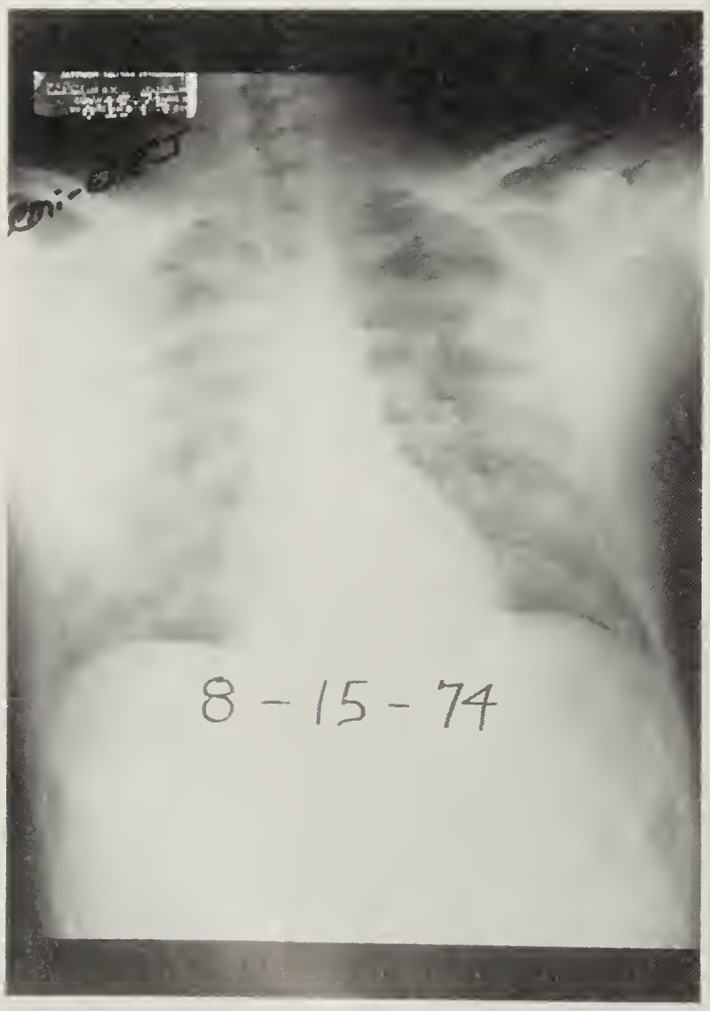


Figure 1. Admission chest x-ray revealing a fluffy alveolar type pattern extending from the hilar regions, compatible with pulmonary edema. Heart size is normal.

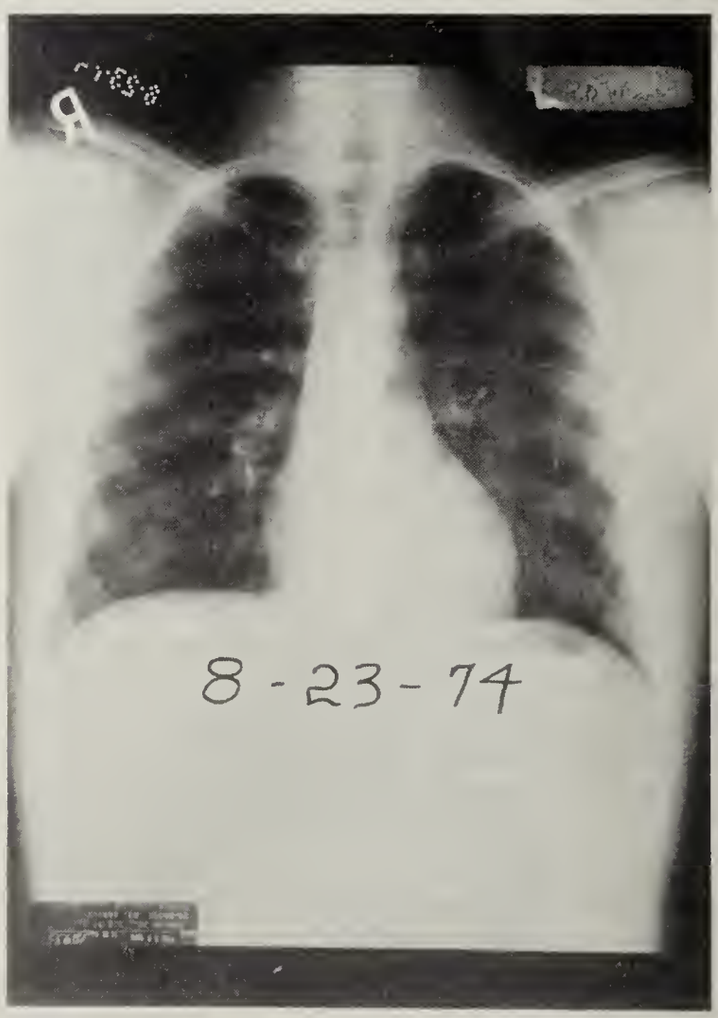


Figure 2. Chest x-ray on the day of discharge is normal.

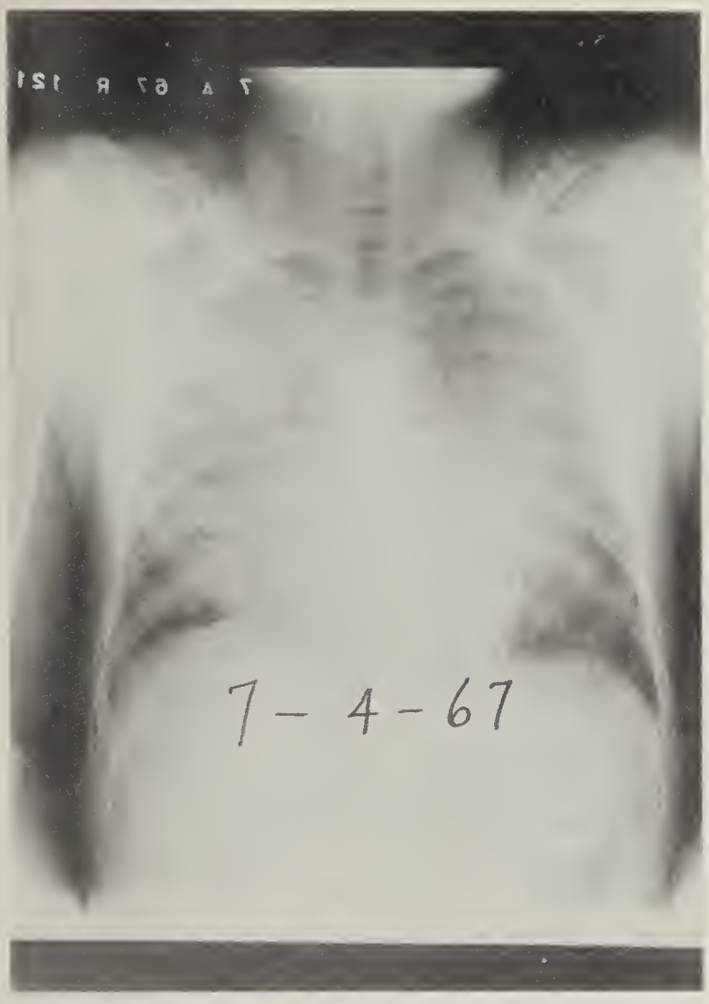


Figure 3. Chest x-ray of another teenaged near-drowning victim on the day of admission. Note the fan-like distribution of pulmonary edema radiating from the hilar areas.



Figure 4. Patient in Figure 3 on the day of discharge; chest x-ray is normal.

osmotic relationship that exists between the fluid in the alveoli and the blood flowing through the pulmonary capillaries. The magnitude of the pathophysiologic changes will be dependent upon the type and amount of fluid aspirated.

Introduction of small volumes of fluid into the lungs produces reflex contraction of the terminal units of the lung; and since these alveoli continue to be perfused, this combination of events results in a ventilation-perfusion ($\dot{V}/\dot{Q}$) inequality. Also, the severe metabolic acidosis may be partially attributed to the massive struggling efforts to survive and resist aspiration of fluid.

Fresh water is hypotonic in relationship to plasma and red cells. There is a rapid transfer of this fluid across the alveolar-capillary membrane and a concomitant increase in blood volume. There is a decrease in plasma osmolarity and viscosity. When the quantity of fluid aspirated exceeds 22 ml per kg, significant reductions in the electrolyte concentrations occur.[3] Hypoxia may cause a release of potassium from the cells producing a subsequent rise in the serum potassium concentration. However, severe electrolyte changes are not usually the acute cause of death in human drowning victims and are minimal compared to the frequency and severity of hypoxemia and acidosis.[4]

Sea water has an osmotic pressure 3.5 to 4 times that of plasma. This marked hypertonicity of sea water causes fluid to leave the vascular compartment and enter the alveoli. Therefore, fluid in excess of that which was aspirated rapidly enters the lungs. Serum potassium and magnesium levels generally increase, and these levels again depend on the volume of sea water aspirated.

Pulmonary Effects. The major problem following all fresh water or sea water drowning is hypoxemia.[5] The mechanisms involved are complex and multiple. The water entering the lungs decreases lung compliance. The lowered compliance may be secondary to reflex mechanisms or to alterations in surfactant or to a combination of factors.

Surfactant lowers surface tension and permits the smaller air spaces to remain open at low transpulmonary pressures. When surfactant is absent, the alveoli collapse, and areas of atelectasis are produced. Fresh water alters surfactant activity so that areas of the lung become unstable, permitting atelectasis to develop. Atelectasis creates areas of perfused, nonventilated lung, or $\dot{V}/\dot{Q}$ inequalities. Also, massive fresh water aspiration may produce marked intravascular expansion resulting in pulmonary and cerebral edema.

Sea water produces $\dot{V}/\dot{Q}$ abnormalities because of the hypertonic fluid in the alveoli and the resulting transudate of plasma into the alveoli. Other lung changes have been found at autopsy including diffuse hyaline membranes, intra-alveolar hemorrhage, inflammatory exudate, and pulmonary thromboembolism. In addition, aspiration of gastric contents or other foreign substances in the water may produce aspiration and pneumonia. Thus, the end result of both fresh water and sea water aspiration is the same: decreased lung compliance, pulmonary edema, hypoxemia, and acidosis—all leading to ventilation-perfusion inequalities.

The most frequent roentgenographic appearance of the chest is that of a diffuse alveolar infiltration throughout both lung fields, usually concentrated in the perihilar and medial basal areas[8] (see Figures 3 and 4). However, lack of roentgen signs may be deceptive, and, again, arterial blood gases must be carefully followed.

Hemolysis. If hypotonic fluid is transfused into the blood stream via the lungs, the red blood cells may be expected to increase in size; and although some may rupture, the remaining cells occupy more space than normal and give a high hematocrit reading. It is not until free plasma hemoglobin is excreted and until isotonic conditions are re-established in the blood stream that the magnitude of red blood cell destruction can be evaluated. Serial hematocrits should be monitored, but the degree of hemolysis is again dependent upon the amount of fluid aspirated.[4]

Therapy. Mouth-to-mouth and cardiac resuscitation should begin upon the victim's retrieval from the water. After his arrival in the emergency room, the primary thrust of therapy is to correct the severe metabolic acidosis and the hypoxemia. Intravenous bicarbonate can be given and oxygen can be administered before the initial lab results are reported. More precise therapy can be instituted after arterial blood gases and pH are known. If the patient is unconscious, intubation should be performed and ventilation begun. Also, a nasogastric tube should be inserted and the gastric contents emptied.

Some authors recommend large doses of methylprednisolone, 15-30 mgm/Kg/24 hours in divided doses, as well as low dose penicillin, both to be administered parenterally.[6] The initial lab values should not lull the physician into a false sense of security. The patient can rapidly deteriorate by suddenly developing the adult respiratory distress syndrome, or "shock lung," and can require positive end expiratory pressures to maintain an acceptable PaO_2.[7] Also, it must be remembered that hemolysis may occur in massive proportions in fresh water victims and that packed red cells may be needed for their oxygen carrying capacity. Conversely, sea water victims may need plasma expanders after an acute decrease in intravascular volume. Tracheostomy will rarely be necessary since marked improvement can usually be expected within 24-48 hours. Arterial blood gases, hematocrit, electrolytes, and chest x-rays should be obtained at frequent intervals. Also, cardiac arrhythmias may occur, and EKG monitoring should continue for at least 24 hours.

Other organs may be involved. Neurologic manifestations vary, but restoring oxygenation usually corrects these. Renal complications are rare, but prolonged hypoxia and acidosis, or massive hemoglobinuria, have produced renal failure.[9]

Digitalis, diuretics, and correction of electrolyte abnormalities may be required in individual cases. In elderly victims pulmonary wedge pressure measurements can aid the physician by determining if the pulmonary edema is pulmonary or cardiac in origin.[10]

SUMMARY

Near-drowning produces pathophysiologic changes that are secondary to aspiration pneumonia, adult respiratory distress syndrome, profound hypoxemia, and metabolic acidosis. Patients should be closely monitored with frequent arterial blood gases, acid-base determinations, and chest x-rays. The physician should not hesitate to institute assisted ventilation with positive and expiratory pressures if necessary. Oxygen, corticosteroids, antibiotics, fluid and electrolyte management, and careful supportive care are the primary therapeutic modalities.[11-13]

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2500 North State Street (39216)

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When a starry-eyed coed invited the captain of the football team to dinner, the robust athlete found the dainty portions disappointing, yielding no more than a taste of this, a sampling of that. Over coffee, his hostess chirped, "I *do* hope you'll let me fix dinner for you again soon?"

"By all means," replied the young man. "Why not start now?"

Comments: Medical Care Status in Mississippi

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Three situations require modification to improve the health status of Mississippians. The first situation needing improvement is the level of health knowledge among the public. Changes in lifestyle through better knowledge could have a very positive impact on the quality of health although this would stimulate additional demand for services. The second situation where improvements could contribute to a better health status is in a more effective means of preventing accidents and treating accident victims. Improved emergency services could have a significant impact on morbidity and mortality due to accidents. The third major situation demanding attention lies in improving accessibility to medical services. A problem in physician distribution and by specialty exists but resolution of this problem in itself will not control the continued public demand for services. The situation is complicated by a discretionary demand for services which outstrips objective medical need. The development of closely associated physician "extendor" personnel is suggested as one means of controlling this discretionary demand and identifying those people with significant medical problems.

HEALTH STATUS indicators such as health manpower measures and the infant mortality rate give a negative view of Mississippi's health status compared to other states. In 1970, Mississippi ranked as the forty-ninth state in its ratio of physicians to population with only Alaska having a smaller ratio. The nation averaged 171 physicians per 100,000 people while Mississippi had 82 per 100,000. Mississippi physicians were not in proportion to the population distribution since the eight major urban counties (containing towns with more than 25,000 people) had 56 per cent of the physicians but 32 per cent of the state's population. Indeed, two of these counties contained some 40 per cent of all physicians with only 16 per cent of the population. There were approximately one million people living in distinctly rural areas with only 400 physicians in these same areas.

Dentist distribution was more sparse than physician distribution. Mississippi ranked lowest of all 50 states in the dentist/population ratio. The nation averaged 47 dentists per 100,000 people in 1970, while Mississippi averaged 24 per 100,000. Like physicians, dentists were concentrated in the urban areas. The state did not have a dental school although one is presently being activated. The pattern for registered nurses is similar to physicians and dentists. The estimated ratio of active registered nurses was 185 per 100,000 people in 1970, but the national average was 345 per 100,000.

It would appear that Mississippi has a low health status due to a lack of health providers since the three major types of providers are available at about half the nation's rate. The infant mortality rate also supports this view. Mississippi has the highest infant mortality rate with 28 deaths per 1,000 births as compared to the national average of 20 deaths per 1,000 births.[1]

A more complete analysis shows the above situation from a different perspective. The infant mortality rate can be stated positively: 972 infants of every 1,000 born in Mississippi will survive their first year while 980 of every 1,000 infants born in other states will reach one year of age. Only 0.8 per cent difference is evident from this perspective. From another perspective, the U. S. has probably reached a point of diminishing return on further significant changes in its infant mortality rate. Table I presents the dramatic decrease in infant deaths which has occurred over the first part of this century. This decrease has slowed greatly in the last 20 years. In retrospect the infant mortality rate might

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primarily reflect problems of nutrition, ignorance, and infectious diseases. Today improved nutrition, education, antibiotics, and immunization have reduced these factors toward a minimal effect level.[2]

TABLE I

UNITED STATES INFANT MORTALITY RATE

Year	1915	1920	1930	1940	1950	1960	1965	1970
Rate per 1,000	99.9	85.8	64.6	47.0	29.2	26.0	24.7	19.8

Source: Statistical Abstract of U.S. Bureau of the Census, page 48; table 57, 1971 edition.

The Mississippi white infant mortality rate was essentially the same as the national average at 20 deaths per 1,000 infants while the black infant mortality rate was approximately 40 deaths per 1,000. In other words, problems with Mississippi's infant mortality rate are race associated and reflect the blacks' lower economic, education, and nutritional status. The difference between the black and white infant mortality rates represents 400 to 600 additional black deaths per year, a point of continuing concern.

The maldistribution and lack of health providers does not affect the major causes of mortality. The four major causes of death are the same for the nation and state, and rates of death are similar. Heart disease, cancer, stroke and accidents took 16,000 lives in 1970 in Mississippi, accounting for approximately 70 per cent of all deaths. Heart disease, cancer, and stroke are the cause of approximately 60 per cent of all deaths and Mississippi has done statistically better for these three causes when compared to the nine states composing the economically affluent New England and Mid-Atlantic states. The six New England states had a death rate of 710 per 100,000 people and the three Mid-Atlantic states had a rate of 735 per 100,000 while Mississippi's rate was 609 per 100,000 people. Similarly in 1968 the New England and Mid-Atlantic states had crude death rates of 10.4 and 10.7 deaths per 1,000 people respectively while Mississippi had a lower rate of 10.2 per 1,000.[3]

However, Mississippi should not be considered as having a substantially lower death rate based upon these numbers. Proper perspective shows that Mississippi had a death rate of only 1 per 1,000 people better than the New England and Mid-Atlantic states for heart disease, cancer and stroke. Age adjusted data strongly indicate that the difference is even less. Likewise, less than one-half death per 1,000 people distinguishes Mississippi from the northeastern establishment crude death rate. Age adjusted data indicate Mississippi has about one death more per 1,000 people.[4] One can restate the crude death rate positively and say that 98.98 per cent of the Mississippi population will survive each year while 98.96 per cent and 98.93 per cent of the people in the New England and Mid-Atlantic states respectively will survive. In this light there appears to be less difference.

One therefore wonders if the lack of manpower in Mississippi is really significant in controlling mortality. For example, New York State ranks first nationally with 234 physicians per 100,000 people or a rate approximately three times as high as Mississippi's. New York also ranks tenth in its nurse to population ratio of 408 per 100,000. Yet New York state has the second highest mortality rate for heart disease and ranks fourth for cancer mortality among the 50 states.[3, 5] It therefore seems reasonable to

TABLE II

PRE-PAID PHYSICIAN STAFFING ESTIMATES

PART A

Estimate of the number of physicians by specialty needed to serve 25,000 people.

Internal Medicine and General Practitioner	10.50-11.00
Pediatrics	3.75- 5.50
Ob-Gyn	2.00- 2.25
Surgery	1.75- 2.25
Ophthalmology	.75- 1.00
E.N.T.	.50- .75
Orthopedics	.50- 1.00
Dermatology	.75- 1.00
Radiology	.75- 1.00
Other	2.00- 2.50
TOTAL	23.25-28.25

PART B

Alternative estimate of the number of physicians by specialty needed to serve 100,000 patients. Is an expansion of the above table in order to identify more specialties.

Internal Medicine	34	Urology	2
General Medicine	10	Dermatology	2
Pediatrics	15	E.N.T.	3
Teen Age	1	Ophthalmology	2
Ob-Gyn	10	Physical Medicine	1
General Surgery	8	Anesthesiology	1
Emergency	1	Radiology	3
Orthopedics	3	Pathology	1
Neurosurgery	1	Administration (Medical Director)	1
Neurology	1	TOTAL	100

Source: "Health Maintenance Organizations," Medical Group Management Association, 1972, pp. 14.

postulate that increases in the number of health providers will not in itself significantly improve the mortality rate beyond a point already reached in Mississippi.

TABLE III

MISSISSIPPI PHYSICIAN MANPOWER NEEDS BY PRE-PAID DATA

	From Part A	*From Part B*
Int. Med. & G.P.	931- 975	975
Pediatrics	333- 488	333
Ob-Gyn	177- 200	222
Surgery	155- 200	177
Ophthalmology	67- 89	44
E.N.T.	44- 67	67
Dermatology	67- 89	44
Radiology	67- 89	67
Others	177- 222	222
Total Physician Demand	2,062-2,508	2,218

Data of Table II converted into these estimates of demand for physicians in Mississippi based upon 1970 population.

Additional support for this position comes from data on prepaid health practices. Mississippi has a need for about 2,050 to 2,500 personnel according to the prepaid data in its recommended physician staffing distribution (see Table III). Of course these numbers have limited value since they do not take into account physician distribution by specialty nor do many physicians work within a prepaid setting. However, as one indicator of demand for physician services, the figures suggest that Mississippi does not have as great a shortage of medical personnel as one might anticipate. With approximately 1,800 physicians (1970 data) in Mississippi there is a demand for 250 to 700 additional physicians in order to achieve the above levels. These numbers indicate a 14 per cent to 39 per cent increase needed in the number of physicians in order to meet demand and are considerably lower than the 100 per cent increase necessary to approximate the national physician to population ratio, or the 300 per cent increase necessary to match the New York State physician to population ratio.[6]

A review of the natural history of the four leading causes of death gives an indication as to why increases in the numbers of health providers will have little effect on the mortality rate. Over much of their latent phase the four major causes of death are mainly under the control of the patient and are preventable or modifiable primarily during this period.



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Once they reach an overt state, however, health providers are able to do relatively little for the patient's basic condition except to attempt to repair or stabilize the acute situations. For the present and foreseeable future health providers cannot prevent or completely cure these entities in the same way that they have been able to sanitize, vaccinate, or use antibiotics for infectious diseases.

In other words, the effective control of the major causes of death can be seen to lie greatly in the patient's lifestyle. The association of smoking, overeating and lack of exercise with heart disease, cancer and stroke has been shown in a variety of studies. Drinking of alcoholic beverages is considered to be a major contributory factor in approximately one-half of all motor vehicle accidents, and deaths occurring in motor vehicle accidents account for approximately one-half of all accidental deaths in Mississippi. The way patients take care of themselves, or rather the way they do not take care of themselves, is the major factor in dying; and health providers face a difficult task in improving the health of the people. Indeed this is an area of social improvement that might be better dealt with by the educational community with the assistance of health providers.

With accidents, however, the system can do more than just educate the public. While accidents are a major factor in gross mortality they are also a major factor in non-mortal health problems. One national study estimates that 13.5 per cent of all acute conditions faced by people in one year (1969) fell in the injury category.[7] Ameliorating conditions following accidents involve three factors: (1) transport, (2) services at the accident site, and (3) hospital based services. Although the first two factors have the greatest visibility and easily glean attention, it is the hospital services factor which is of major importance. Even when appropriate first aid and rapid transport are critical the ability of the hospital to respond appropriately remains essential.

Since World War II emergency room services have been the fastest growing area of hospital care. Hospitals have responded to increasing use of emergency services by providing more accessible services and the number of patients has increased even more under this positive stimulus. It is a common observation that the overwhelming majority of people coming to emergency rooms are not emergencies nor critically ill. Rather they are people who could be just as easily treated in a physician's office if they found it convenient.

It is on this issue of convenient primary care that the real problem resulting from Mississippi having few physicians becomes apparent. The present number of physicians may be sufficient to deal as effectively as elsewhere with major lethal problems, but it is not sufficient to deal with routine problems or to make people more comfortable while recovering from illness. The medical care system faces severe overloading in providing accessible primary care. Patients are using the system to maximum capacity whenever given the opportunity and the continued rapid growth of emergency room services shows that the total demand is not being met.

An indication of the magnitude of this demand is reflected in information on the number of acute problems which restrict peoples' activities or require people to seek medical attention. The rate has been averaging slightly more than 400 million problems per year for the nation's population. Approximately 42 per cent (170 million) of the problems were not attended medically but restricted the activity of the person.[8] Other data indicate that there were approximately 840 million physician contacts in 1969. Although the greatest majority occurred within the office setting (70.1 per cent), telephone consultations accounted for 12 per cent of the contacts while emergency room consultations accounted for another 10.3 per cent.[9] These numbers suggest that many people did not find physicians accessible when needed or made inappropriate use of emergency rooms and telephone consultations because physicians were not accessible within their offices. These data are not broken down by state but it is reasonable to assume that the situation is similar in Mississippi.

Improved access to primary care services may be accomplished by expanding the medical school's enrollment, emphasizing the primary care specialties, and structuring the residency programs to stimulate the dispersal of young physicians throughout the state. Unfortunately this may be a necessary but insufficient solution. The system is and will be increasingly strained as economic restrictions are reduced on the use of services by the increased availability of federal, state, and private third party payers. This increased economic demand does not just result from bona fide medical problems, but also from other less tangible factors.

Research on prepaid health plans where economic restrictions are reduced shows that physicians are faced with differentiating between patients not requiring physician care from those who do. Large numbers of people who previously could not obtain health services due to economic restrictions are now

in increasing competition with those who think they need physician services but do not.[10] One medical barrier is being replaced with another.

Several socioeconomic studies indicate that a large and latent reservoir of medical care demand exists and can be tapped as constraints are reduced or changed. There appears to be much elasticity in the demand for physician services which is primarily dependent upon a person's educational level and reinforced with economic affluence. Depending upon how one controls for variations in family income, there is a 150-200 per cent increase in physician visits for children under 15 years of age as their patients' education increases from less than five years to more than 13 years. In the specialist areas of pediatrics and obstetrics-gynecology there are even more dramatic increases in the percentages of population that use physician services based upon years of education. Depending upon how one controls income, there are increases of 300-650 per cent in the use of physicians' services as the level of education increases from less than nine years to more than 13 years (see Tables IV and V).[11]

TABLE IV

Number of physician visits per person per year by education of head of family and family income for persons under 15 years of age, July 1966-June 1967.

	Education of Head of Family				
Family Income	UNDER 5 YEARS	5-8 YEARS	9-12 YEARS	13+ YEARS	PERCENTAGE CHANGE FROM LOWEST TO HIGHEST
Under $5,000	2.1	2.2	3.2	5.4	+157
$5,000 and over	1.4	2.6	4.1	5.0	+257

Source: National Center for Health Statistics, Volume of Physician Visits, 1966-1967, Series 10, No. 49 (1968), p. 23.

An indication of the size of this discretionary demand is given in the previously discussed data on physician visits. Some 4.2 per cent of the physician visits in 1969 were for vaccinations and immunizations although these services are frequently available from other services, i.e. public health facilities. The common cold causes the greatest number of visits, accounting for more than 41 million in 1969, or 4.9 per cent of all visits.[12]

The two specialties of pediatrics and obstetrics are particularly open to emotional considerations and the stimulus of education is sufficient to overcome

TABLE V

Per cent of population using selected types of medical specialists and practitioners by family income and education of head of family, July 1963-June 1964.

	Education of Head of Family			
Type of Visit and Income	UNDER 9 YEARS	9-12 YEARS	13+ YEARS	PERCENTAGE CHANGE FROM LOWEST TO HIGHEST
Pediatric				
Under $4,000	4	15	30	+650
$4,000 and over	10	20	38	+280
Obstetrics-Gynecology				
Under $4,000	2	7	11	+450
$4,000 and over	4	10	16	+300

Source: National Center for Health Statistics, Characteristics of Patients of Selected Types of Medical Specialists and Practitioners, July 1963-June 1964, Series 10, No. 28, Department of HEW.

economic restrictions for both the poorer and richer segments of the population. Parents are more likely to seek physician services for their children than they are for themselves. Women also have strong emotional concerns when considering obstetrical or gynecological care. One would not expect such dramatic increases in physician demand by the general adult population when emotional factors are not so great and where economic restrictions are considered more carefully. The data in Table VI support this view. Physician visits increase 10-20 per cent for adults as education increases from less than five years to more than 13 years. This implies a considerable potential for an expansion in discretionary demand should the general public come to expect medical care as a "right" which should be funded by third party payers.

Economists state that the medical profession greatly controls the demand for its services as well as supplying them. This situation comes about because medical practice is based upon such specialized knowledge that patients cannot decide what they need in the way of services. Therefore, the physician decides what type of service and how much should be provided. The medical marketplace contains a situation in which demand is not completely controlled by the demanders but is controlled in part by the supplier of goods and services.[13]

There also appears to be a discretionary component in that part of the demand for services which is controlled by physicians. A recent economic study shows that where physicians are relatively numerous, there is an increased demand for their collective

services. This demand can be increased by asking patients to come back for more follow-up visits, seeing more patients in the same period of time, or expanding chronic continuing care services. This is not to say that physicians consciously manipulate the marketplace, but rather to recognize that these elements have effects. Physicians simply request more follow-up visits with complicated cases or see more routine health problems as time becomes available.

Conversely, if physicians are relatively few within an area the demand for their collective services decreases and the amount of services each must provide individually increases. In other words, a physician will spend more time taking care of acute medical problems and leave the less acute for later if time is available.[14] Since many health problems are self curable this might be the most effective way to work.

TABLE VI

Number of physician visits per person between 15-64 years of age.

	Education of Head of Family					
Family Income	UNDER 5 YRS.	5-8 YRS.	9-11 YRS.	12 YRS.	13+ YRS.	PER CENT CHANGE FROM LOWEST TO HIGHEST
Under $5,000 ...	4.2	5.0	5.0	5.1	4.3*	+2 (+21)*
$5,000 and over .	3.9	3.7	4.0	4.2	4.4	+13

* This number reflects the heads of families of working age, having more than a high school education, but still having little income. Such people are frequently in unusual circumstances (unemployed, crippled, etc.) and represent only a small percentage of the population (less than 2 per cent). It therefore is better to consider this number a statistical artifact and exclude it. If excluded, the change is 21 per cent.

Source: National Center for Health Statistics, Physician Visits, 1969, Series 10, No. 77, pp. 24, 39, Department of HEW.

It therefore appears that at least two major social and psychological factors are involved in the analysis of accessibility to care. On the one hand there appears to be a large discretionary demand for physicians among patients primarily stimulated by the patients' level of education. On the other hand there is also discretionary control of demand by physicians depending upon the acuteness of the problem. The interaction of these two main factors results in the load placed upon the system. A resulting state of tension is maintained between physicians and the public due to an apparent lack of services which in fact actually may be minimal.

A major need in Mississippi (and the nation) therefore, is to develop some means of controlling the discretionary demand for services from both the patient and physician perspectives in addition to affecting the specialty and geographic distribution problem. Some of the prepaid health plans have attempted to control this demand through the use of multiphasic screening in order to differentiate those patients not requiring physician services from the acutely ill. However, these methods are not comprehensive in that all diseases cannot be identified through screening processes nor do patients become ill at the screening laboratory's convenience. Also patients will seek physician services when they think they have a problem and not when a laboratory analysis states they do. In other words, medical care still relies upon human interaction and not on mechanical technique or methodology alone.

Retrospective thought on discretionary demand shows that three basic criteria must be met in order to successfully control it. As indicated above, the demand control must be done in a way which is satisfactory to patients. Secondly it must be satisfactory to the physician. Finally the solution must present a stabilizing influence upon the cost for third party payers. For example, multiphasic screening may be criticized as being a potentially inflationary influence although it may help to control or decrease costs by identifying certain diseases in their latent state. Extra services for well patients are required and must be reimbursed at the expense of savings from identifying latently ill patients. Pressure for stabilizing costs will increase as third party payers demand more effective controls. Federal support for such programs as HMO's and PSRO's indicates the magnitude of this pressure.

The development of personnel who are distinctly assistants and "extendors" of physician services in a task directed manner provides a means of meeting the above criteria. The "extendor" personnel can distinguish levels of acuteness and guide patients as necessary, or deliver services under physician supervision, particularly to patients not needing direct physician care. By influencing the flow of patients to physicians these personnel assist in the control of the public discretionary demand and may help to stabilize some costs. An "extendor's" counseling is readily accepted by patients. Finally, by "extendors" being closely associated with physicians, the physician can have confidence that he, the physician, is properly controlling medical care delivery.

Such personnel already exist in various settings. Many physicians have nurses who routinely review

patients before the physician actually sees them. Years of experience have given the physician confidence in the capability of the nurse to assist in treating the more acutely ill patient and to filter out those who do not need immediate attention. Another example is the midwifery program presently working in the state. Less intimately controlled personnel may be seen in the public health nurse or the hospital employed nurse working in such areas as intensive care units.

The physician "extendor" also offers a means to affect the distribution of manpower. Even if the number of physicians were to increase by several hundred to meet the levels previously discussed, the great majority would practice within the larger cities and towns and not the more rural areas. Therefore, it may be easier for physicians, hospitals or health departments to employ "extendors" in rural areas. It should be noted that these personnel would and should act as supplementors and not be surrogate physicians.

In summary, three situations stand out needing modification in order to improve the health status of Mississippi. The first is the need for considerable improvement in the level of health knowledge among the public. A change in lifestyle through better knowledge could have a very positive impact on the quality of health. The second need is a more effective means of preventing accidents and treating accident victims. Improved emergency services could have a significant impact on morbidity and mortality due to accidents.

The third major situation requiring action lies in improving accessibility to physicians where medical needs are sufficiently acute. There is a problem in physician distribution geographically and by specialty, but resolution of this problem in itself will not control continued public demand for services. The situation is complicated by a discretionary demand for services which outstrips objective medical need. The development of closely associated physician "extendor" personnel is suggested as one means of controlling this discretionary demand and identifying those people with significant medical problems. ★★★

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Radiologic Seminar CLI: Mammography

ELMER J. HARRIS, M.D.
Jackson, Mississippi

STATISTICS of the American Cancer Society snow that this year alone there will be an estimated 90,000 new cases of breast cancer and 33,000 deaths from the disease, making it the largest single contributor to death in American women. It is now believed that the mortality rate from this disease can be significantly reduced by augmenting standard manual breast examinations with national mammographic screening programs for high risk groups. For early detection it is felt that every woman should do breast self-examinations monthly and should have physical examinations at least annually after the age of 30. Mammography should be done annually or bi-annually for the following high risk groups: (1) Where a breast has been removed for cancer, (2) where there is a family history of breast cancer, (3) where there is proliferative manifestation of cystic disease, (4) where there is breast symptomatology, (5) if a previous biopsy has been made, (6) if no palpable mass can be felt but if it is believed that there has been a change in a portion of the breast on self-examination.

In general, mammography is most effective in detecting early cancer in women over 50, but some what more limited in younger individuals. For that reason some authorities recommend that all women after the age of 50 have annual mammography as part of routine physical examination. Mammography can be done either by a film technique or by a xeroradiographic technique, each of these methods having their advocates.

I believe that mammography should be considered to be approximately 85 per cent accurate in identifying carcinomas. A primary aim of mammography is the discovery of cancers that escape detection by all other means. In a referral type practice Wolfe found in a series of 462 cases of cancer that 139 or 30 per cent of these were of the occult type (not palpable), this being higher, however, than most other reported series.

In interpreting mammography films primary signs of malignancy are: (1) Presence of mass, (2) tumor calcifications, (3) abnormalities of the ductal pattern.

Secondary signs making one suspicious of malignancy include: (1) increased vascularity, (2) skin thickening, (3) skin retraction, (4) nipple retraction. Figures 1 and 2 show typical radiographic fea-



Figure 1. Note the spiculated mass with irregular margins.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Hospital, Jackson, Miss.

tures in a 67-year-old female with adenocarcinoma of the left breast.

On occasion mammography can detect a breast cancer before palpation of the mass is possible. Mammography, however, should be employed with the understanding that it is an adjunctive method of physical examination and its diagnostic accuracy does not substitute for biopsy of a palpable lesion. If mammography does not show an abnormality of the breast it does not rule out cancer. The tendency to be reassured by mammography when it is normal is difficult to overcome but one must constantly bear in mind that a carcinoma may be lurking in an area of the breast not seen on the x-ray film or it simply may not be of sufficient density to be separable on the x-ray film, especially in the pre-menopausal patient. If adequate physical examination does not disclose a mass but the mammogram is positive, biopsy is indicated. If there is an indication for biopsy on physical examination and the mammogram is normal, then biopsy is still needed. ★★★

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Figure 2. On the same patient, multiple uncountable small calcifications are demonstrated as well as mass lesion, skin thickening, and retraction of the skin.

MAY 1975: High Blood Pressure Month

Dermatology Course Set for New York

A three-day dermatopathology symposium entitled "Histologic Diagnosis of Inflammatory Skin Diseases," sponsored by the departments of dermatology and pathology of New York University School of Medicine, will be held June 26-28. Directed by Dr. A. Bernard Ackerman, associate professor of dermatology and pathology, it will take place in Alumni Hall, NYU Medical Center, 550 First Avenue, New York City.

The course is designed to provide a logical and reproducible approach to the diagnosis and understanding of inflammatory skin diseases. A method will be taught for making specific histologic diagnoses in most inflammatory skin diseases, thus avoiding their being signed out as "chronic nonspecific dermatitis." Careful clinicopathological correlation will also be emphasized.

The format will be 45- to 60-minute lectures followed by a 30-minute question and discussion period in which the faculty will participate. Representative examples of all categories of inflammatory skin diseases will be available for microscopic study.

The tuition is $200 and for residents in training, $100. For details write Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York, N. Y. 10016.

Genitourinary Radiology Course Set

The Department of Diagnostic Radiology and the Division of Urology, Department of Surgery, will present a symposium on Genitourinary Radiology at the Lexington Hilton Inn May 14-16, 1975.

Prior to the meeting, each registrant will be mailed a set of 2″ x 2″ slides of unknown case presentations that demonstrate distinguishing diagnostic characteristics. The program format will consist of panels analyzing the unknown cases as well as of formal talks. Registration fee is $225.

For further information write: Dr. Frank R. Lemon, Office of Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

Medical Group Management Association of Mississippi

Purpose is to improve business administration in medical groups in order to serve better the members of the association, the medical groups they represent, and medical group practice.

Members are persons in the active supervision of the business affairs of three or more licensed doctors of medicine, with common facilities, actively engaged in the practice of medicine. Quarterly meetings are held the 3rd Wednesday of the 2nd month of each calendar quarter and annual dues are $10.00.

For more information contact Mrs. Pat Shepperd, Secretary, 940 North State Street, Jackson, MS 39201, phone (601) 354-4836.

107th ANNUAL SESSION OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

May 5-8, 1975

at the

Sheraton-Biloxi

Biloxi, Miss.

Scientific Sections

Annual Meeting of the House of Delegates

Scientific and Technical Exhibits

Social and Alumni Occasions



The President Speaking

All Roads Lead to "Rome"

J. T. DAVIS, M.D.
Corinth, Mississippi

THIS MAY 4, 1975, all roads lead to Biloxi to the 107th Annual Session of the Mississippi State Medical Association.

As this goes to press, the sound of the gavel reverberating throughout the "Top of the Sheraton" will be announcing the beginning of our scientific session, a session filled with special events for everyone.

For those who come to learn there is an impressive scientific program of continuing medical education. For those who come to play there is sunshine, the beach, fishing, boating and golf. For he who comes to lead and legislate there is the House of Delegates and the political arena.

The issues of the day will be of prime consideration and the decisions far reaching in their influence. This annual session should prove to be exciting, eventful and profitable to everyone.

This has been a great year for your President, self satisfying and filled with enriching experiences. Probably the most rewarding was the privilege and opportunity of talking and associating with the top level people in the state of Mississippi—the members of the medical profession.

I will be looking forward to seeing "you all" in Biloxi on May 4.

★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVI, NUMBER 5
MAY 1975

EDITORIALS

The Early Diagnosis of Breast Cancer

The early detection of carcinoma of the breast remains a source of major concern to American women and to the doctors responsible for their care. With proper treatment the ten year survival of women with early cancer without metastasis is 75 per cent. After metastasis has occurred to the regional lymph nodes the survival rate drops to 30 per cent. Thus, early detection becomes the one most important factor in long time survival.

The educational effort of the American Cancer Society in teaching self-examination of the breasts has been of great value in the early detection of cancer, but needs to be expanded, especially to include the low income groups. Unless women seek medical advice while the breast cancer is still in early stages, the survival rate will remain poor.

Once a physician finds a mass in a patient's breast he is obligated to make a definite diagnosis. If it is a cyst it should be aspirated, but if the mass is solid or if a tumor persists after aspiration, a biopsy becomes mandatory.

Mammography has recently become one of the most popular methods of early breast cancer detection. In expert hands an accuracy rate of 70 per cent can be expected. Xerography and thermography are newer diagnostic aids, but not as readily available.

Careful examination of the breasts by a physician knowledgeable in the field of breast cancer remains the most valuable diagnostic procedure available. Roentgenologic evaluation may or may not confirm the clinical impression, but should be correlated with all other findings in reaching a valid conclusion.

GEORGE H. MARTIN, M.D.
Associate Editor
Vicksburg, Miss.

Is the Grass Greener?

The notion that "grass" (marihuana) is harmless has enjoyed a high degree of acceptability with little if any scientific support. Several respected individuals (and publications) have advocated legalization of marihuana on the basis of what amounts to little more than an assumption that it is harmless.

Since 1969 evidence suggesting potential hazards has accumulated at a rapid pace. These 5 years of research have provided strong evidence suggesting that marihuana in its various forms may be far more hazardous than was originally suspected.

This does *not* mean that one "joint" or even a "few joints" will cause significant harm. What the evidence does suggest is that:

* the effects are cumulative;

* the effects are dose-related;

* prolonged heavy use of marihuana (or the more potent hashish) is statistically associated with at least six different types of potential health hazard.

These six types of hazards are:

1. chromosome damage—Stenchever et al (University of Utah School of Medicine) demonstrated more than a two-fold increase in chromosome breakage in cannabis users than in non-users. This amount of breakage is comparable to 150 roentgens of ionizing radiation and has the same potential for hazard according to Hardin B. Jones at the University of California (Berkeley). Other studies have produced seemingly contradictory results;

2. disruption of cellular metabolism—may disrupt synthesis of DNA, and interfere with the functioning of the immune system;

3. may mimic hormones—may act to produce a variety of effects ranging from impotence and temporary sterility to the development of female-like breasts in men;

4. severe debilitation of respiratoy tract—much in the same manner as tobacco smoke;

5. personality changes—may lead to a marked deterioration in what is "normally" considered good mental health;

6. brain damage—potentially irreversible brain damage may occur.

Studies of this kind are difficult to conduct since it is difficult to determine potency of cannabis exposure, since many users take other drugs, and since the patient's memory is heavily relied upon for history reconstruction. However, the available study data and clinical observations indicate that "grass blowing" is not the innocuous pastime it was thought to be.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

REFERENCE

Science, Volume 185, Number 4152, 683-685.

May Is High Blood Pressure Month

May is High Blood Pressure Month and MSMA is one of the organizations helping the Mississippi Heart Association to promote awareness of the need for hypertension screening.

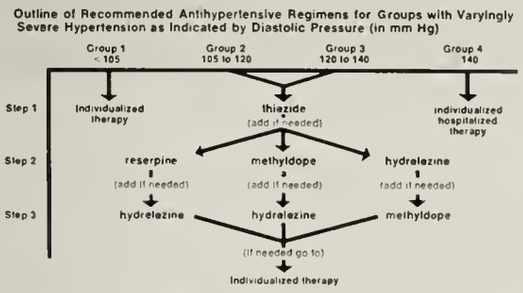
According to heart association statistics, there are about 300,000 persons in the state who have hypertension and around 150,000 cases have been undetected. Mississippi has twice the national average of incidence.

Physicians are urged to check every patient for hypertension. Indigent patients found to have the disease can be referred to the county health department for free drugs with the permission of their personal physician. For further information on this program contact Dr. Laurance Clark, State Board of Health, P.O. Box 1700, Jackson 39205.

The following is a list of trade names and manufacturers corresponding to the generic name on High Blood Pressure desk card provided to the Mississippi Heart Association through cooperation of Dr. Mickey C. Smith, Professor and Chairman of the Department, Department of Health Care Administration, School of Pharmacy, The University of Mississippi.

Generic Name	*Trade Name*	*Manufacturer*
Reserpine	Elserpine	Canright
	Lemiserp	Lemmon
	Rau-sed	Squibb
	Resercen	Central
	Reserpoid	Upjohn
	Sandril	Lilly
	Serpasil	Ciba
	Serpate	Vale
	Vio-serpine	Rowell
	Lemiserp Ty-Med	Lemmon
	Rauren D-Lay	Westerfield
Hydralazine	Apresoline	Ciba
	Lopress	Tutag
Methyldopa	Aldomet	MSD
Chlorothiazide	Diuril	MSD
Hydrochlorothiazide	Esidrix	Ciba
	Hydrodiuril	MSD
	Oretic	Abbott
Hydroflumethiazide	Saluron	Bristol
Bendroflumethiazide	Naturetin	Squibb
Benthiazide	Aquapress	Coastal
	Aquatag	Tutag
	Duicen	Central
	Edemex	Savage
	Exna	Robins
	Lemazide	Lemmon
	Proaqua	Reid-P.
Trichloromethiazide	Naqua	Schering
	Metahydrin	Lakeside
Methylclothiazide	Aquatensen	Mallinckrodt
	Enduron	Abbott
Polythiazide	Renese	Pfizer
Cyclothiazide	Anhydron	Lilly
Chlorthalidone	Hygroton	USV
Quinethazone	Hydromox	Lederle
Spironolactone	Aldactone Tabs	Searle
Triamterene	Dyrenium Caps	SKF
Furosemide	Lasix	Hoescht
Ethacrynic Acid	Edecrin	MSD
Rauwolfia	Hyper-Rauw	Sutliff and Case
(whole root)	Raudixin	Squibb
	Rauval	Vale
Alseroxylon	Rautensin	Dorsey
	Rauwiliod	Riker
Deserpidine	Harmonyl	Abbott
Rescinnamine	Moderil	Pfizer
Syrosingopine	Singoserp	Ciba
Guanethidine	Ismelin Sulfate	Ciba
Mecamylamine	Inversine HCl	MSD
Pentolinium	Ansolysen	Wyeth
Hydroflumethiazide (flumethiazide)	Saluron	Bristol

The information in the following table was adapted from National High Blood Pressure Education Program Task Force 1, Sept. 1973. For further information contact the Mississippi Heart Association, P.O. Box 16063, Jackson, Miss. 39206.—N.G.



Outline of Recommended Antihypertensive Regimens for Groups with Varyingly Severe Hypertension as Indicated by Diastolic Pressure (in mm Hg)

Therapeutic Objective: Diastolic Pressure under 90 mm Hg or, if side effects cannot be tolerated, under 100 mm Hg.

All hypertensives should have treatment for any lipid disorder and obesity and should be instructed to stop smoking cigarettes and to engage in appropriate regular exercise.
Report of Inter-Society Commission for Heart Disease Resources, Circ. Vol. XLIV, Nov. 1971

Basic Dosage and Time Recommendations for Antihypertensive Regimens

	Group 2 Diastolic pressure 105 to 120 mm Hg		Group 3 Diastolic pressure 120 to 140 mm Hg	
DRUG DOSAGE*	Initial dose (mg/day)	Maximum dose (mg/day)	Initial dose (mg/day)	Maximum dose (mg/day)
Diuretics	(Begin with half dose and increase in one step to full dose if needed)		(Begin with full dose)	
Reserpine	0.1	0.25	0.1	0.25
Methyldopa	500	2000	750	3000
Hydralazine	30	200	75	300
Time interval	Average interval (months)	Maximum interval (months)	Average interval (months)	Maximum interval (months)
Interval between visits while BP is being lowered	½	2	¼	1
Interval between visits when BP is under control	2	4	2	4
Interval between re-examinations and repeat lab work	6	12	6	12

*Diuretics and reserpine can be given in single daily doses. Methyldopa and hydralazine should be given in 2 to 4 divided doses.

For complete information on action, side effects, and contraindications of antihypertensive drugs see: Hypertension Drug Treatment, 1973 and Hypertension Office Evaluation, 1972, American Heart Association

Available Oral Diuretics

	Full Dose (mg/day)
A. SULFONAMIDE DERIVATIVE DIURETICS	
Thiazides	
Chlorothiazide	1000
Flumethiazide	1000
Hydrogenated Derivatives	
Hydrochlorothiazide	100
Hydroflumethiazide	100
Substituted Compounds	
Bendroflumethiazide	5
Benzthiazide	100
Trichlormethiazide	4
Methyclothiazide	5
Polythiazide	8
Cyclothiazide	2
Chlorthalidone	100
Quinethazone	100
B. POTASSIUM-SPARING DIURETICS	
Spironolactone	100
Triamterene	300
C. NON-SULFONAMIDE DIURETIC AGENTS — Most potent oral diuretics, but more liable to induce side effects than milder agents	
Furosemide	80
Ethacrynic acid	100

Antihypertensive Drug Data

	Usual daily dose (mg) Initial	Maximal
A. RAUWOLFIA ALKALOIDS		
Rauwolfia (whole root)	100.0	200.0
Alseroxylon	1.0	2.0
Reserpine	0.1	0.25
Deserpidine	0.25	0.25
Rescinnamine	0.25	2.0
Syrosingopine	1.0	3.0
B. METHYLDOPA	500.0	3000.0
C. HYDRALAZINE	50.0	300.0
D. GUANETHIDINE	12.5	No limit
E. GANGLION BLOCKING AGENTS		
Mecamylamine	2.5	No limit
Pentolinium	2.5	No limit

Medico-Legal Briefs

PROFESSIONAL CORPORATION DENIED DAMAGES FOR PHYSICIAN'S INJURIES

In the first of two cases arising from injuries a physician sustained in an automobile collision, a Louisiana appellate court ruled that he could not recover damages for injuries caused by a prior accident. In the second case, the court ruled that his professional corporation could not recover damages for loss of his services due to the injuries.

In 1969, the physician sustained cervical injuries in an automobile accident. A myelogram showed that he had a ruptured cervical disc at C-5. He was treated conservatively until May 1972, when a bout of sneezing exacerbated the pain.

He then made an appointment for consultation and treatment. While he was driving to keep that appointment, his car was struck from behind by an auto driven by another physician.

Claiming damages for injuries received in the second accident, the physician brought an action against the other physician and his insurance company. The trial court awarded him $25,000 for physical injuries and $239.30 for hospital expenses. He appealed the award as inadequate.

On appeal, the Louisiana court said some of the injuries suffered by the physician were the result of the 1969 accident, not the 1972 accident. Shortly after the 1972 accident, the physician had undergone an anterior interbody fusion at the C-5 level. About a month later, he began to have a recurrence of his previous symptoms. That condition was diagnosed as a herniated disc at the C-4 level caused by the greater stress placed on it by the fusion at C-5 and C-6. The 1972 accident also contributed to emotional disturbances.

Concluding that the evidence showed that the physician-driver was not responsible for the ruptured C-5 disc or the ruptured C-4 disc, the Louisiana appellate court affirmed the award of $25,239.30. That sum included $25,000 for aggravation of physical condition, pain, suffering, and emotional disturbance, plus $239.30 for medical expenses.

In the second action, the physician's professional corporation sought damages for loss of working time due to the physician's injuries and damages to the car, which was owned by the corporation. The trial court allowed $900 for damage to the car but denied the claim for lost time. The corporation appealed.

On appeal, the court said that no precedent existed for allowing recovery by the corporation for loss of the physician's services. The analogy to a corporation's insurable interest in key personnel was not persuasive. The damages claimed by the corporation were too remote, speculative, and merely consequential to the accident, the court concluded. The trial court's judgment was affirmed.—*Baughman v. Aetna Casualty & Surety Company,* 302 So.2d 312 (La.Ct. of App., Oct. 14, 1974); *Baughman Surgical Associates, Ltd. v. Aetna Casualty & Surety Company,* 302 So.2d 316 (La.Ct. of App., Oct. 14, 1974)

LETTERS

SIRS: Again, this year I am compiling case reports of allergic reactions to biting insects, i.e., mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc.

I would like physicians to supply me with case reports of those patients who have had reactions to such insects. Include in your reports the type of reaction and complications, if any, the age, sex, and race of the patient, the site of the bite(s), season of the year, immediate symptoms, skin test results, desensitization results, if any, and any associated other allergies. Send this information to me at the following address: Claude A. Frazier, M.D., 4-C Doctors' Park, Asheville, NC 28801.

NEW MEMBERS

AKINS, CHARLES D., Iuka. Born Trezevant, Tenn., Aug. 12, 1943; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1973; interned Baptist Memorial Hospital, Memphis, Tenn., one year; elected by Northeast Mississippi Medical Society.

BUCHANAN, BENJAMIN H., JR., Tupelo. Born Hattiesburg, Miss., Sept. 25, 1943; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1969; interned Memorial Medical Center, Savannah, Ga., one year; orthopaedic surgery residency, University Medical Center, Jackson, Miss., 1970-74; elected by Northeast Mississippi Medical Society.

MASSEY, MITCHELL C., McComb. Born Bruce, Miss., Feb. 14, 1941; M.D., Louisiana State University School of Medicine, New Orleans, La., 1967; interned Good Samaritan Hospital, Portland, Ore., one year; radiology residency, LSU, Shreveport, La., 1970-73; elected by South Central Medical Society.

PERSONALS

JIM C. BARNETT and D. L. BOLTON of Brookhaven announce the new location of The Family Clinic on Hwy 51 North.

New board of directors for Garden Park Community Hospital in Gulfport are J. L. BARKLEY, R. G. BURMAN, D. L. CLIPPINGER, J. B. EDWARDS, R. A. LITTLE, and O. C. RAINES, III.

DONALD J. BOOTH of Biloxi announces the association of JOHN J. ZIELINSKI for the practice of surgery at 1210 W. Division Street.

C. D. BOUCHILLON of Laurel and PAUL H. MOORE of Pascagoula have been named Fellows of the American College of Radiology.

FRANK W. BOWEN of Carthage has been elected president of the Leake County Chamber of Commerce.

H. D. BROCK and A. J. YATES of Jackson announce the removal of their offices for the practice of pediatrics to 1824 Hospital Drive.

New Diplomates of the American Academy of Family Physicians are MICHAEL R. CASEY of Laurel; IRVIN H. CRONIN, JOHN E. MANN, JR., and EUGENE G. WOOD, JR., all of Jackson; PRENTISS F. KEYES of DeKalb; JUDSON F. LLOYD of Natchez; JAMES S. MCILWAINE, JR., of Clinton; LOUIS JENNINGS OWENS of Woodville; JOHN E. POWELL of Houlka; LOUIS A. RUBENSTEIN of Ocean Springs; and GRAYDEN TUBB of Fulton.

ROBERT L. DONALD of Pascagoula has been elected to the board of the First National Bank of Jackson County.

ANSE B. HOWARD, III, of Louisville has opened Howard's Clinic at 408 South Church Avenue.

T. D. LAMPTON of Jackson has been elected chairman of the Southeastern Regional Medical Programs coordinators.

DEWEY LANE of Pascagoula is serving as vice president and will be president-elect for 1976 of the Mississippi Economic Council.

RUSSELL R. LYLE of Starkville has been named a Diplomate of the American Board of Pediatrics.

Francis S. Morrison of Jackson and UMC attended the Council of Community Blood Centers annual meeting in Scottsdale, Arizona. Dr. Morrison presented a paper, "Post Transfusion Purpura," at the South Central Association of Blood Banks meeting in New Orleans.

Bernard S. Patrick of Jackson and UMC presented a paper, "Ubiquitous Neck Pain," to the American Medical Tennis Association meeting in Austin, Tex.

Curtis D. Roberts of Pearl announces the association of Douglas W. Rouse for the family practice of medicine at McLaurin Medical Center.

Thomas R. Singley of Pascagoula, J. Elmer Nix of Jackson and John M. Patterson of Pontotoc have been appointed to the University of Mississippi General Alumni and Medical Alumni Boards of Directors.

Robert R. Smith of Jackson and UMC presented a paper, "Pathological Anatomy of Cerebral Artery in Vasospasm," at the Southern Neurosurgical Society meeting in San Antonio.

James P. Spell of Jackson announces the limitation of his practice to diagnosis and treatment of breast diseases. His office is located at 500-D East Woodrow Wilson Drive.

William L. Wood of Tupelo was a recent guest speaker to the Tupelo Luncheon Civitan Club. Dr. Wood, president of the Mississippi Heart Association, spoke on heart disease.

Dr. Mitchell Named Miss. PSRO Director

Dr. Tom H. Mitchell of Vicksburg has been appointed Executive Director of the Mississippi Foundation for Medical Care—Professional Standards Review Organization. Dr. Mitchell's appointment was announced by the chairman of the board of the 1,300 physician member organization, Dr. James O. Gilmore of Oxford, at a recent meeting of the board at the foundation's office in Jackson.

The Mississippi Foundation for Medical Care is one of 13 physician-sponsored professional standards review organizations in the country approved by the Department of HEW to review the quality and necessity of health services furnished to beneficiaries of the Medicaid, Medicare and Maternal and Child Health Programs. It was organized for this purpose by the Mississippi State Medical Association in 1973.

Dr. Mitchell has been a family physician in Vicksburg since 1948. A member of the staff of The Street Clinic he has served as Medical Director and Chairman of the Department of Family Practice of that institution. He is a past-president of the Mississippi Academy of Family Physicians and holds membership in the West Mississippi Medical Society, Mississippi State Medical Association, American Medical Association and American Academy of Family Physicians.

Dr. Mitchell is married to the former Ann Gibson of Canton. He is an Elder in the First Presbyterian Church of Vicksburg. His numerous civic and professional activities include service as a volunteer physician to Viet Nam in 1968, member of the Mississippi State Board of Nursing, Chairman of the Committee on Nursing and Council on Constitution and By-Laws of the Mississippi State Medical Association and Director on the Central Mississippi Health Planning Council. He received his B.S. Degree from Mississippi State University and his M.D. from Tulane University.

Congress Considers Medical School Support

The House Health Subcommittee has approved a health manpower bill authorizing $1.7 billion over three years to support medical and other health profession education. Under the proposal similar to the House-passed bill last year, medical schools would receive capitation support of $2,100 for each student for 1976 and 1977, with support decreasing to $2,000 per student in 1978. The bill provides a simple extension of present health manpower authority for this year.

Medical schools would be required to either increase their enrollment or provide for remote site training for at least 50 per cent of their students in their last two years of medical school education. Medical students would be required to pay back to the U. S. Treasury capitation amounts paid to schools on their behalf, but would be given capitation payback forgiveness, on an equal year-for-year basis, for time spent in the National Health Service Corps or service in private practice in medically underserved areas.

Approved medical residencies could not exceed 155 per cent of the previous year's graduating class

starting in 1978 as a restriction on foreign medical graduates. In 1979 and 1980, limitation would decrease to 140 per cent and 125 per cent. The Coordinating Council on Medical Education could administer the residency limitation, but if it does not agree to accept such administration, the government would do so.

Designated as primary care specialties would be General and Internal Medicine, Pediatric Medicine, Family Medicine, and Obstetrics and Gynecology.

Senator Edward Kennedy (D-Mass.) has introduced four bills dealing with health manpower, including his sweeping plan of last year calling for mandatory service and licensing and re-licensing. This was rejected in the last Congress by the Senate in favor of Senator J. Glenn Beall's (R-Md.) more limited plan. House and Senate could not reach agreement on the legislation last year.

Kennedy's health subcommittee will hold hearings on the four bills in a month or so. MSMA has been assured of continued opposition to the Kennedy proposals by Mississippi's Congressional Delegation.

History of Medicine Society Meets

The History of Medicine Society will meet on Thursday, May 15, at 6:30 p.m. in the Ole Miss Medical Alumni House, Jackson.

Guest speaker will be Dr. Jose Bebin, professor of pathology (neuropathology), University Medical Center. His topic will be "Trephinement in Ancient Peru."

For further information or reservations, contact Dr. John Y. Gibson, Department of Radiology, UMC.

DEATHS

HACKMAN, PEARL E., Gulfport. Born Salford Township, Pa., Oct. 18, 1897; M.D., Woman's Medical College of Pennsylvania, Philadelphia, Pa., 1924; interned Reading Hospital, Reading, Pa., one year; emeritus member of MSMA and AMA; died Feb. 24, 1975, age 77.

SCHMIDT, FRANK O., Ocean Springs. Born Ocean Springs, Miss., Nov. 16, 1902; M.D., Tulane University School of Medicine, New Orleans, La., 1930; interned Charity Hospital, New Orleans, La., one year; died Feb. 25, 1975, age 72.

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

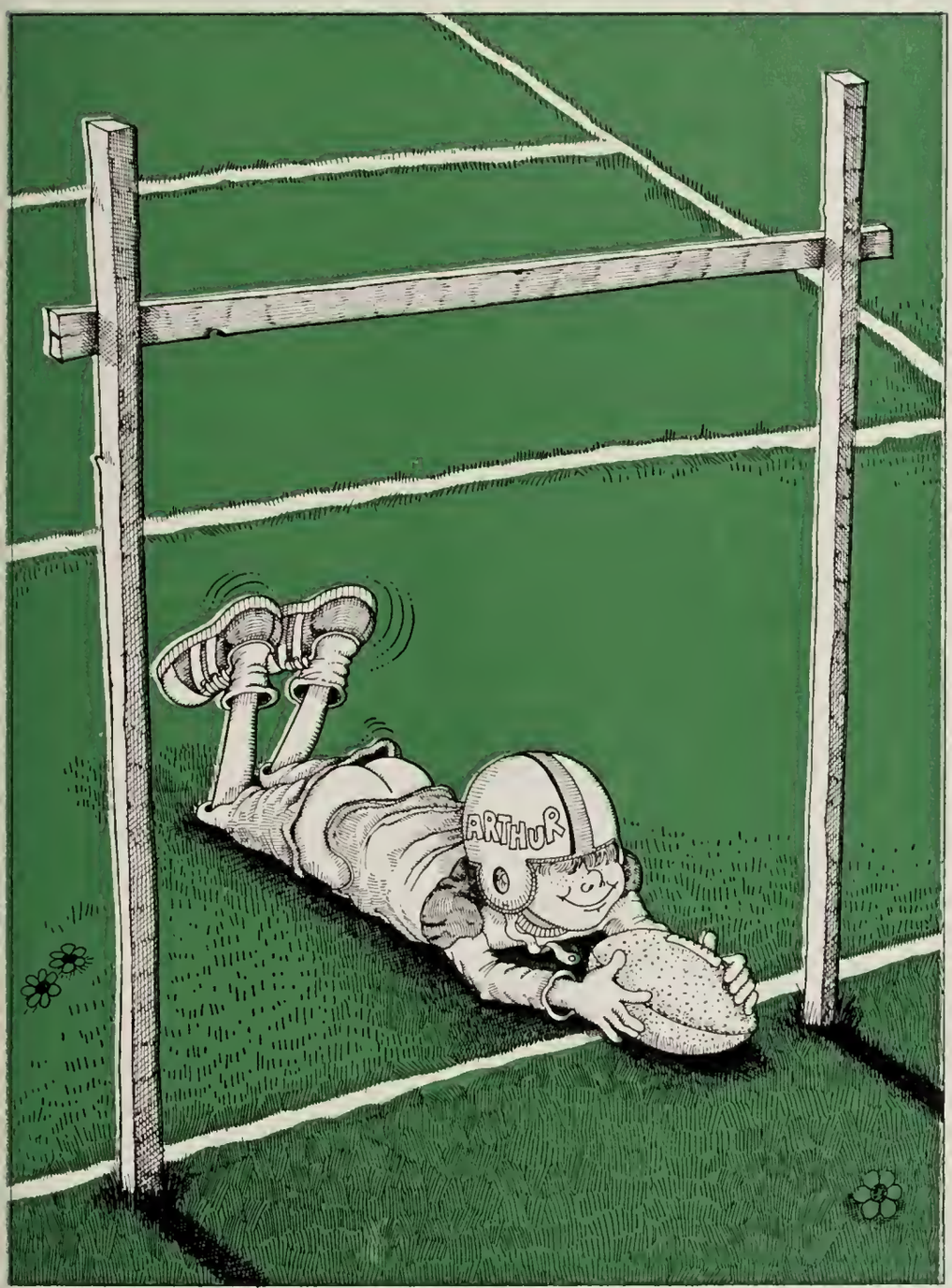
Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
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WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
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Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

Tri-State Cardiology Meet Scheduled

The 1795 Tri-State Scientific Sessions for Physicians will feature Current Topics in Cardiology May 14-16 at the Worthen Building in Little Rock, Ark.

The sessions are cosponsored by the Arkansas, Louisiana and Mississippi heart associations and the American Heart Association Council on Clinical Cardiology. Dr. W. H. Rosenblatt of Jackson represented Mississippi on the Tri-State Committee.

Heart association members' registration fee is $65. For nonmembers the fee is $75. The program has been approved for 12 hours of credit by the AMA and the American Academy of Family Practice.

New UR Regulations Are Postponed

HEW Secretary Caspar W. Weinberger has announced that the effective date for implementation of the utilization review regulations in hospitals and other health care facilities participating in the Medicare and Medicaid programs has been changed from Feb. 1, 1975, to July 1, 1975.

"A number of questions about requirements and interpretation of the utilization review regulations have been raised since their publication, and some small rural hospitals have expressed concern about their ability to conform to these regulations," the Secretary said. "We have decided to move the effective date of the regulations so as to allow all providers to come into full compliance and to avoid the loss of eligibility to participate in the Medicare and Medicaid programs before July 1," he added. Secretary Weinberger said the department would also use the time to work out special problems that may be faced in small rural hospitals.

Facilities with small medical staffs, especially those in rural areas, may have difficulty organizing the in-house review committees to operate the review system required by the regulations, the Secretary said. "For these facilities, several alternative means of complying with the law are provided in the regulations. State survey agencies and departmental personnel will be available to work with the small facilities on these alternatives so that they can develop review systems that comply with the regulations."

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

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Dr. John D. Bower Is Named Mississippi's Physician of the Year

Dr. John D. Bower, associate professor of medicine and director of the Artificial Kidney Unit, University Medical Center, has been named "Mississippi's Physician of the Year" by Governor William L. Waller.

Governor Waller, representing the Governor's Committee on Employment of the Handicapped, and the Mississippi State Medical Association, co-sponsors of the nomination, presented Dr. Bower a certificate of merit.

Dr. Bower will be considered by the President's Committee on Employment of the Handicapped this spring in selecting the "Physician of the Year" for the nation.

Governor Waller said Dr. Bower "almost singlehandedly established in Mississippi an outstanding program of treatment for end-stage renal disease patients, with emphasis on the rehabilitation of his patients."

"His program has served as a model for many similar treatment programs developed throughout the United States," Governor Waller stated.

The Governor listed as Dr. Bower's major achievements:

"First, he established an artificial kidney unit at the University Medical Center in 1965, so that for the first time Mississippians with terminal kidney disease no longer had to die."

Dr. Bower faced many obstacles in establishing the unit. Funding was a major problem, Waller said. The physician secured a U. S. Public Health Grant and financial backing from the Mississippi Kidney Foundation.

"Second, he secured the financial help of the Mississippi Vocational Rehabilitation division in establishing at the Medical Center a Home Unit program to train patients and their spouses in the use of the artificial kidney machine.

"His belief that many of the patients could be rehabilitated and returned to work was the basis for the agency supporting the Home Unit program, purchasing the artificial kidney machines for home use and providing other rehabilitation services to patients who qualified.

"These home units made it possible for many of the patients to discontinue making the twice-weekly trips to Jackson for dialysis at the Kidney Unit. Now they could dialyze at their homes and return to full-time jobs," the Governor explained.

"Third, Dr. Bower sparked the organization over the state of a network of satellite centers—treatment centers—most of them housed in trailers. These centers are located near hospitals, so that staff help is available to kidney patients when needed. Since a number of patients use one center on a rotating basis, the cost of dialysis for each patient is greatly reduced."



Governor William Waller is shown presenting a certificate of merit to Dr. John D. Bower of Jackson, Mississippi's Physician of the Year. Attending the ceremony were Mr. Charles Ryan, chairman of the Governor's Committee on Employment of the Physically Handicapped, and Mr. Charles L. Mathews, MSMA Executive Secretary.

Dr. Bower heads a flying team who visits the satellite centers on a regular basis, holding clinics, and assisting patients and administrators with their problems.

A native of Westfield, MA, Dr. Bower obtained his doctor of medicine degree from the Medical College of Virginia in 1961. He served his internship and junior assistant residency at the Medical College of Virginia Hospital, and was a fellow in renal physiology and chief resident at the same hospital. Dr. Bower served with the U. S. Navy, 1951-55.

Dr. Bower became instructor in Medicine, University of Mississippi School of Medicine, and attending physician and consultant in medicine, Veterans Administration Hospital, Jackson, July 1, 1965.

He was named director of the Artificial Kidney Unit, 1965; assistant professor of medicine, University Medical Center, 1967; project director, regional medical program comprehensive renal training program, 1969; associate professor of medicine, University Medical Center, 1971; and assistant professor of physiology and biophysics, School of Medicine, University of Mississippi Medical Center, 1972.

The 1975 Legislative Session

The 1975 Legislature witnessed the enactment of several important health-related laws during its final 90-day session of the 1972-76 term. A total of 76 bills which either directly or indirectly affected health care were introduced in the 1975 Legislative Session and 12 of these measures were ultimately passed by both the House and Senate and signed into law by Governor Waller. Two of these 12 measures were sponsored by MSMA as part of its four-point legislative program, and eight of the remaining ten were all supported by the association upon recommendation of the Council on Legislation.

MSMA, pursuant to directives of its House of Delegates, sponsored four proposals during the 1975 session to accomplish the following: (1) authorize a 28-day life span for CPD-preserved human blood; (2) update the state's statutory commitment procedures to mental institutions; (3) set minimum standards for Health Maintenance Organizations through regulation by the Insurance Commissioner; and (4) authorize the State Board of Health to certify and regulate physician assistants. The Council on Legislation also elected to sponsor legislation that would increase the existing statutory basis for reimbursing physician services under the Medicaid program.

Bills authorizing a 28-day life span for CPD-preserved blood (HB 323) and updating commitment procedures (HB 930) were passed by both houses and signed by the Governor. The three remaining measures all died in a committee of the House or Senate, but it is perhaps worth noting that the association's proposal to increase physician fees under Medicaid (SB 2249) passed the Senate before meeting its demise in the House Public Health and Welfare Committee. Likewise, MSMA's measure authorizing the State Board of Health to regulate physician assistants passed the House prior to being killed by the Senate Public Health and Welfare Committee. The remaining association-sponsored measure that would have established minimum operating standards for HMOs died in the House Insurance Committee without consideration.

In addition to the two proposals noted above, the following health related bills were enacted during the 1975 Legislative Session:

HB 203—directs county health departments to provide free testing and treatment of venereal disease and to maintain strict confidentiality of the individual tested and/or treated.

HB 487—this so-called "Disabled Physician Act" authorizes the State Board of Health to suspend or restrict the license of any physician determined to be laboring under any physical and/or mental disabilities. Determination of disability will be conducted by a committee of physicians selected by MSMA for the specific purpose of conducting the examination. This legislation was recommended by the AMA Law Department as a model act and Mississippi was the first state to secure its enactment.

HB 558—amends the legal definition of "hospital records" in Mississippi to exclude such information as PSRO and utilization review committee reports, thereby making them exempt from judicial process or subpoena.

HB 1067—authorizes the State Board of Health to license and regulate speech pathologists and audiologists. Personnel working directly for a physician/employer are excluded from the provisions of this act.

SB 2058—authorizes the State Board of Health to require an annual registration of all physician, osteopathic or podiatric licenses for accountability purposes at a fee of $10.

SB 2063—authorizes the State Board of Health to reinstate a physician's license which they have

otherwise suspended or revoked, thus eliminating the requirement that a physician petition the court for reinstatement of his license.

SB 2091—defines the types of disciplinary actions which the State Board of Health may take against a physician, osteopath or podiatrist other than revocation or suspension of the license.

SB 2173—increases the state's loan program for medical students from $5,000 to $24,000 with a semi-forgiveness provision for any graduate practicing in a community of less than 7,500 residents.

SB 2743—adds certain drugs to the state's controlled substances schedule.

HB 614—include licensed practical nurse in "good samaritan law" which exempts physicians and RNs from civil liability resulting from and/or treatment at scene of an emergency.

Also of importance is the fact that none of the proposals opposed by association were enacted during the 1975 Legislative Session. Chief among these MSMA opposed bills were measures requiring health insurance policies to pay for chiropractic services and authorizing chiropractic participation in the Medicaid program, in addition to numerous bills permitting optometrists to diagnose, use drugs and legally call themselves "doctor."

VD Awareness Program Held in Oxford



Participating in a recent University of Mississippi program on venereal disease awareness were Dr. Eric McVey (right), health officer of Hinds, Madison and Rankin counties; Lynn Sloan (second from right), U. S. Public Health Service, Jackson; and pharmacists (from left) Jimmy Coker, New Albany; Carl Catt, New Albany; Glenn Adair, Olive Branch; and Wilson Allen, Memphis. Sponsors were the Ole Miss School of Pharmacy, State Board of Health, and Mississippi State Pharmaceutical Association.

Physicians Study Newborns at UMC



Dr. John E. Rawson, right, assistant professor of pediatrics at the University of Mississippi School of Medicine, demonstrates equipment in the newborn center to Dr. C. D. Taylor of Pass Christian, left, and Dr. Frank Dement of Hattiesburg, both participants in a course on treatment of problems in the newborn at the Medical Center. The UMC Department of Pediatrics, Division of Newborn Medicine, and Division of Continuing Health Professional Education sponsored the three-day session.

Health Costs Rise

The medical care sector showed price increases in February that were above those in the economy in general and the all services sector in particular. The all items category of the consumer price index rose 0.7 per cent in February, compared to 0.5 per cent in January. The all services index rose 0.8 per cent, the same increase as in January. Both the medical care component and physicians' fees rose by 1.2 per cent. The increase in the medical care component was slightly less than the 1.3 per cent increase in January, but the increase in physicians' fees was higher than the January increase of 0.9 per cent.

A partial explanation for the rising pattern of physicians' fees and the medical care component, offered by the AMA's Center for Research and Development, is that fiscal years for hospitals and physicians are typically calendar years and price

adjustments are often made within the first quarter of the fiscal year. If the pattern of outpacing the all services index continues, the center said, critics will conclude that physicians are no longer restraining their fee increases, and renewed criticism from the government must then be expected. The renewed rise in physicians' fees relative to the rest of the economy has not yet brought fees to the point of exceeding the increase in prices in general in the long run, the center said.

Second Annual UMC Surgical Forum Held

Eleven nationally known surgeons were on the faculty for the Mar. 13-15 second annual UMC postgraduate surgical forum. More than 200 surgeons from 37 states participated in the meeting held at the Jackson Hilton.

Sponsors were the Department of Surgery and the Division of Continuing Health Professional Education, and coordinators were Dr. W. O. Barnett, professor of surgery, and Dr. James D. Hardy, professor of surgery and chairman of the department.

Guest speakers discussed advances in colon, gastrointestinal, endocrine, pancreas, and breast surgery.



Dr. H. William Scott, Jr., professor of surgery and chairman of the department, Vanderbilt University, left, discusses gastrointestinal advances with Dr. Raymond S. Martin, Jr., of Jackson.



Dr. J. T. Davis of Corinth, at right, and Dr. Robert S. Caldwell of Tupelo confer during break at the UMC second annual surgical forum.

Lung Research-Education Project Established

A special Mississippi Lung Association Research-Medical Education Fund has been established, according to an announcement by Mrs. Mary Jane Green of Grenada, president of the Christmas Seal Association. Mrs. Green announced that $10,000 will be available for awards to Mississippians for special research in lung and respiratory diseases or for special projects in medical education.

The MLA Research-Medical Education Fund is designed to stimulate pulmonary research and encourage new researchers. Christmas Seal dollars invested in research studies will benefit those who suffer from the many lung and respiratory conditions such as chronic bronchitis, asthma, emphysema, tuberculosis, and pneumonia. The MLA Board of Directors included the medical education phase in the research project since pediatric lung and respiratory problems are increasing at an alarming rate and since there are shortages of specialists in all areas of pulmonary medicine, including physicians, nurses and inhalation therapists.

Fully funded by Mississippi Christmas Seal contributions and gifts to Memorial and Emphysema Research Funds, this project will highlight research opportunities and advanced training for medical and

other health professionals interested in lung, respiratory, and pulmonary diseases conditions. Mrs. Green stated that the Mississippi Lung Association Research-Medical Education Fund will be available to research investigators in Mississippi medical schools, universities and/or hospitals and may be in the medical, clinical, surgical, laboratory, epidemiological aspects of lung diseases and/or their relationship to air pollution or cigarette smoking.

Awards, limited to Mississippians, will be made on competitive merit basis for unique and non-duplicative research or medical education projects. Mrs. Green said that grant applications are available from the association's office in Jackson.

Mrs. Green added that in order to advance medical research into causes and cures of pulmonary problems, this pilot program will be continued on an annual basis, provided sufficient funds are available from contributions for the project. The long range MLA Research-Medical Education Fund goal is the prevention and control of crippling lung diseases and the hope of better respiratory health for all Mississippians.

For more information on criteria and grant applications, contact the Mississippi Lung Association, 353 N. Mart Plaza, Jackson, Miss. 39206 or call 362-5453.

Meridian Will Host Maternal-Infant Meets

In May, Meridian will host two maternal-infant care workshops University of Mississippi Medical Center faculty are conducting this year at hospitals throughout the state.

Dr. Donald Sherline, professor of obstetrics and gynecology and director of maternal-fetal medicine at the Medical Center, is program coordinator.

The May 13 and May 27 workshops in Meridian, tentatively scheduled for Holiday Inn Northeast, are for all health professionals in the field of maternal-child care—obstetricians and gynecologists, family practitioners, public health physicians and nurses, nurse-midwives, and other nurse practitioners.

Dr. Sheldon Kushner and Dr. E. M. Jones are in charge of local arrangements and have helped plan the program covering such subjects as high risk pregnancy, fetal monitoring, and immediate care of the newborn.

The University of Mississippi School of Medicine Departments of Obstetrics and Gynecology and the UMC Division of Continuing Health Professional Education sponsor the one-day workshop, supported by a Bureau of Community Service (HEW) grant to the American College of Obstetricians and Gynecologists.

PSRO Is Discussed at UMC



Dr. Tom Mitchell, second right, private physician from The Street Clinic in Vicksburg, talks with UMC officials, from left, Dr. Carl Evers, associate dean for medical student affairs, Dr. Norman C. Nelson, UMC vice chancellor, and Dr. Richard Miller, associate dean of the School of Medicine, about professional review in Mississippi. Dr. Mitchell is chairman of the executive committee of the Mississippi Foundation on Medical Care which has set up standards for professional review in the state. According to Dr. Mitchell, Mississippi's review procedures will be well established statewide before the 1976 deadline issued by federal authorities.

UMC Researchers Study Blocking Factors

Immunologists at the University of Mississippi Medical Center have evidence that blocking factors are probably the mechanisms which allow certain areas of the body to retain foreign tissue longer than others.

Dr. James B. Grogan, Dr. Robert Vessella, and Dr. Seshadri Raju implanted skin tissue into the anterior chamber of rats' eyes. The chamber, along with the male testes and the meninges of the brain are all known to be privileged sites because of their tolerance of foreign tissue.

The UMC research, supported by the National Institutes of Health, indicated that the rat's body responded to the alien tissue in the eye long before it could bring about the rejection process.

After the skin was placed in the rat's eye, the

Medical Center investigators replaced a piece of the recipient's skin with a piece of skin from the original donor. The rat's body began rejecting the second graft immediately at an accelerated pace, but retained the tissue in the eye for many weeks.

"We don't yet know what these blocking factors are, but we know they exist," Dr. Grogan said.

The investigators believe the blocking mechanisms which stop antibodies from rejecting a transplant are the same factors which may allow some cancers to grow unchecked.

The results of the UMC studies were read before the immunology section of the Federation of American Societies for Experimental Biology in Atlantic City, New Jersey, and have been submitted for publication in the *Journal of Immunology*.

In further research with rats, the team will investigate tumors.

"We want to see how the blocking factors work with malignant tissue," Dr. Grogan said.

Hypertension Month Committee Organized



Dr. Fred Tatum (seated) of Hattiesburg is leading the group organized to direct and coordinate the statewide high blood pressure educational activities during the month of May, National High Blood Pressure Month. Assisting Dr. Tatum are: (Left to right) Dr. Laurance Clark, Jr., Mississippi State Board of Health; Dr. A. B. Brittou, Jr., Mississippi Medical and Surgical Association; Mrs. Ruth White, Mississippi State Medical Association Auxiliary; Mrs. Ollye Shirley, Mississippi Medical and Surgical Association Auxiliary; and J. B. Powers, Hattiesburg businessman. Not pictured are: Mrs. Nola Gibson, Mississippi State Medical Association; Jim Buffington of Aberdeen, Mississippi Broadcasters; and Sam Cameron, Mississippi Hospital Association.

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

May 7-9, 1975

NEWBORN COURSE FOR PHYSICIANS

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education and Department of Pediatrics Division of Newborn Medicine with support from Mississippi Regional Medical Program and the Public Health Service, Department of Health, Education and Welfare

Coordinator:
John E. Rawson, M.D., assistant professor of pediatrics, the University of Mississippi School of Medicine, and director of the Newborn Center

The curriculum will focus on normal adaptation, identification of abnormal condition, and management of the sick newborn.

May 19-23, 1975

FAMILY PRACTICE REVIEW FOR PHYSICIANS

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from Mississippi Regional Medical Program

Coordinator:
Roland B. Robertson, M.D., assistant dean for continuing education, School of Medicine, School of Health Related Professions, and School of Dentistry and director of the Division of Continuing Health Professional Education, the University of Mississippi Medical Center

Thirty-two local faculty members will participate and target their presentations toward the realities of family practice, with emphasis on office practice. Sample topics include coronary heart disease, hypertension, pediatric emergencies, and new developments in gynecology.

JOURNAL

OF THE Mississippi

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JUNE 1975

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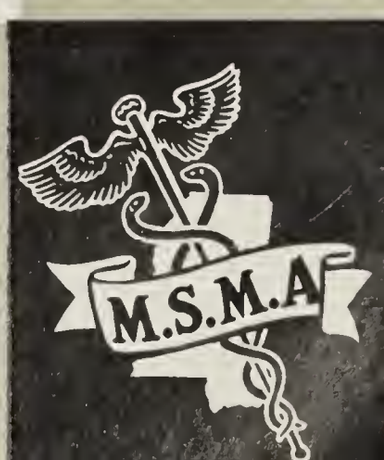


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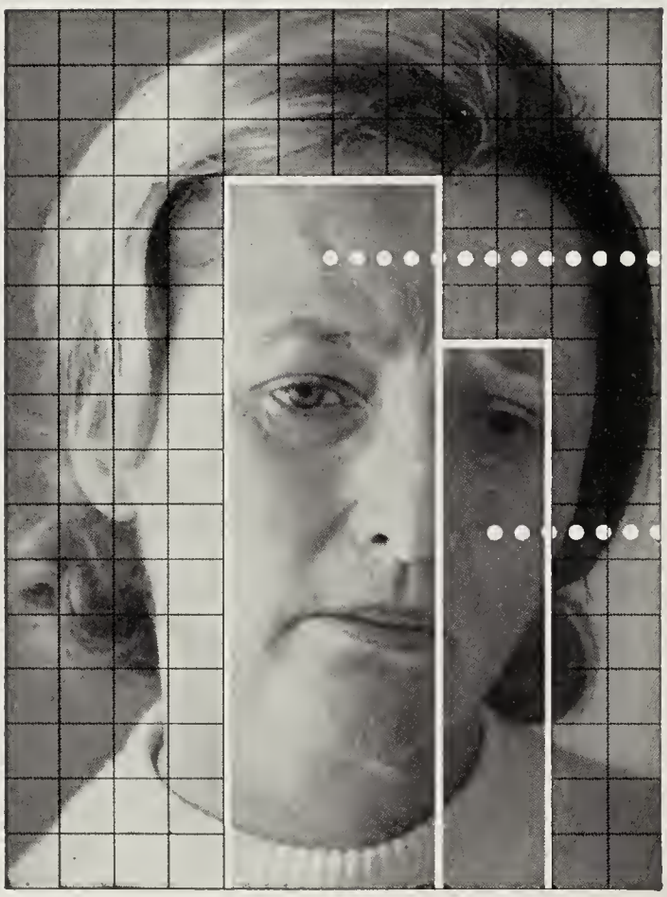
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This Month . . . Lipid Abnormalities, Sick Sinus Syndrome, Ultrasound Scanning, 107th Annual Session



Both often



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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard ant convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
June 1975, Vol. XVI, No. 6

ORIGINAL PAPERS

The Recognition and Medical Management of Lipid Abnormalities

JAMES R. GALYEAN, III, M.D.
Jackson, Mississippi

The author discusses the relationship of elevation of serum lipids and risk of developing atherosclerosis. He describes specific lipoprotein types in detail and gives a simplified diagnosis of lipid abnormalities. A listing of lipid lowering drugs concludes the article.

ALTHOUGH EVIDENCE that elevation of serum lipids is associated with the risk of developing atherosclerosis is clear, some controversy exists as to whether the relationship is causal. Opposition to stringent dietary controls has been based on the fact that lowering serum lipids may have little influence on the natural history of coronary atherosclerosis once it has developed. These debates notwithstanding, until the relationship of lipid abnormalities to atherosclerosis, specifically coronary atherosclerosis, is more clear, it seems prudent to advise that attempts be made to identify and control these abnormalities.

The first step in the diagnosis of lipid abnormalities is to determine the level of cholesterol and triglyceride. The sample to be studied may be either plasma or serum. The patient should have fasted for 12 to 14 hours before the blood is drawn, as recent caloric intake may significantly alter triglyceride levels. It is preferable that the patient not be on a weight reduction diet, hypolipidemic agents, birth control pills, or steroids. If a patient has recently suffered a myocardial infarction or undergone surgery, a 6 to 8 weeks interval should be allowed before lipids are studied. The suggested upper limits of normal are shown in Table I. It should be emphasized that "normal" limits are not the same as "safe" limits. The levels of cholesterol and triglyceride that are defined as "abnormal" by Fredrickson and Levy have been set at the upper 5 per cent of the distribution in "normal" Americans. However, the risk of atherosclerosis is probably increased even in those who are in the upper range of normal. Fredrickson's rule-of-thumb regarding lipid abnormalities is that any person whose cholesterol concentration is greater than 200 mg per cent plus his age in years or whose triglyceride concentration is greater than 150 mg per cent has sufficient lipid abnormality to require the attention of his physician.[1] It is important to know the method used for the determination of lipids in the laboratory. Different methods of determination give different normal values, and some laboratories do not run adequate quality controls.

Although simple determination of cholesterol and triglyceride levels is helpful, it is now possible to characterize lipid abnormalities more precisely. It is known that lipids are transported in the serum in the forms of lipoprotein complexes, which may be identified by properties such as electrophoretic mobility. Several different types of lipoprotein abnor-

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mality have been identified, each of which has certain laboratory and clinical characteristics.[2, 3] A brief review of the different types of lipoproteins may be helpful in further discussion of their abnormalities.

Chylomicrons are particles of fat absorbed from the intestine, normally present only in the postprandial state. They contain small amounts of cholesterol and phospholipid, but are extremely rich in triglyceride. High-density lipoproteins (HDL), or alpha-lipoproteins, contain very little triglyceride, being primarily composed of phospholipid and cholesterol in approximately equal amounts. No clinical abnormality is associated with high HDL concentrations. Low-density lipoprotein (LDL), or beta-lipoproteins, normally account for approximately three-fourths of cholesterol, but also contain small amounts of triglyceride and phospholipid. Very low-density lipoproteins (VLDL), or pre-beta-lipoproteins, are rich in triglyceride, transporting most of the triglyceride synthesized endogenously. VLDL also contain small amounts of cholesterol and phospholipid. Intermediate-density lipoproteins (IDL) contain cholesterol and triglyceride in approximately equal amounts, with a small amount of phospholipid being present also. In summary, the abnormalities associated with high triglyceride include elevation of chylomicrons and VLDL, whereas high LDL are associated primarily with cholesterol elevation. Abnormalities of IDL may be associated with elevation of both cholesterol and triglyceride.

TABLE 1

LIMITS OF CHOLESTEROL, TRIGLYCERIDE, AND LDL[1]

Age	*Cholesterol*	*Triglyceride*	*LDL*
0-19	230	140	170
20-29	240	140	170
30-39	270	150	190
40-49	310	160	190
50-59	330	190	210

It is important to remember that lipid abnormalities may be primary, or secondary to coexisting diseases. A careful search should be made for these, as management of many of the secondary hyperlipoproteinemias involves treatment of the underlying disease. If a primary lipid abnormality is identified it is also important to study relatives of patients who may have familial types of lipoprotein abnormalities.

SPECIFIC LIPOPROTEIN TYPES[1-3]

Type I Hyperlipoproteinemia (Hyperchylomicronemia). This familial disorder, fortunately rare, is seen in children. These patients are deficient in the enzyme lipoprotein lipase, which is responsible for clearing chylomicrons from plasma. As a result, there is severe intolerance to dietary fat, large amounts of chylomicrons being absorbed. The cholesterol is normal or slightly elevated but triglycerides are markedly elevated, with levels up to 15,000 mg per cent being seen. The lipoprotein electrophoresis reveals a heavy chylomicron band. Refrigerated serum separates into a "cream" layer and a clear infranatant.

These patients may have multiple bouts of abdominal pain, some of which simulate an acute surgical abdomen. Pancreatitis and hepatosplenomegaly are seen. Eruptive xanthomata occur on the trunk and extremities and some patients have lipemia retinalis, a creamy-white appearance of the retinal vessels due to the large triglyceride concentration of plasma. Secondary Type I hyperlipoproteinemia may be associated with uncontrolled insulin-dependent diabetes mellitus, hypothyroidism, dysglobulinemias, alcoholism, pancreatitis, and various autoimmune diseases, including lupus erythematosis.

The only satisfactory treatment is dietary restriction of fat, no effective drug therapy being available. Fat is restricted to 25-35 gm daily, with substitution of medium-chain triglycerides to make up approximately 25 per cent of daily caloric intake. Protein and carbohydrates are not restricted, but alcohol should be avoided.

Type II Hyperlipoproteinemia (Hyper-Beta-Lipoproteinemia). Type II hyperlipoproteinemia may be divided into two subtypes, IIa and IIb. In type IIa, LDL are elevated, with the cholesterol generally being 300-600 mg per cent, the triglycerides normal, and electrophoresis showing a densely staining beta band. Standing, refrigerated serum is clear. In Type IIb abnormality, both LDL and VLDL are elevated, with cholesterol being similar to Type IIa but with the triglycerides also being moderately high. The electrophoresis shows staining of both beta and pre-beta bands, and standing serum is slightly turbid.

This disorder may be familial and inherited as an autosomal dominant. Secondary forms may be associated with hypothyroidism, dysprotcinemias, nephrotic syndrome, multiple mycloma, porphyria, and obstructive liver disease. Patients may have tendinous xanthomata, tuberous xanthomata, palpebral xanthomata, and arcus senilis. This abnormality is

frequently associated with accelerated atherosclerosis.

Dietary therapy of Type IIa hyperlipoprotcinemia includes restriction of cholesterol to 300 mg or less daily and increase in the intake of polyunsaturated fats, especially in the form of corn, soy, or safflower oils. It should be noted that many non-dairy items said to contain vegetable oil contain coconut oil or cocoa butter. Although these are of plant origin, they are high in saturated and short-chain fatty acids and must be avoided. Many patients with Type IIa hyperlipoproteinemia are overweight, and caloric restriction is necessary to obtain ideal body weight. Otherwise, carbohydrate intake need not be restricted. Alcohol may be used in moderation.

Patients with IIb abnormality may attain normal lipid levels simply by a prudent weight-reduction diet. Restriction of both cholesterol and carbohydrates may be necessary, however, to lower both LDL and VLDL.

If dietary measures fail to control this lipid abnormality, drug therapy may be effective. At the present time, cholestyramine is the drug of choice. Some success has also resulted from the use of cholestyramine plus nicotinic acid. Clofibrate has limited value in the treatment of this lipid abnormality. It should be emphasized that drug therapy is an adjunct to, not a substitution for, scrupulous dietary control.

Type III Hyperlipoproteinemia. In this abnormality there is an elevation of IDL, more precisely, of abnormal LDL in the VLDL fraction. Cholesterol and triglyceride levels are abnormal, cholesterol being in the range of 300-800 mg per cent and triglyceride 400-800 mg per cent. The lipoprotein electrophoresis shows a broad, heavily-stained band extending from the beta to the pre-beta position. Occasionally, a faint chylomicron band is seen. The standing, refrigerated serum appearance is variable, depending on the triglyceride level. If triglycerides are low, the serum may be only slightly cloudy; however, those patients with high triglyceride levels will have a turbid serum, and, if chylomicrons are present, a faint creamy layer may occasionally be seen. A presumptive diagnosis of Type III hyperlipoproteinemia may be made from the cholesterol and triglyceride levels, the standard electrophoresis, and examination of standing serum. The definitive test, however, is a demonstration of the abnormal lipoprotein by more specialized tests, such as ultracentrifugation.

The genetics of the primary disorder is not clear, but evidence suggests that it is inherited as an autosomal recessive trait. Secondary forms are seen in hypothyroidism, dysglobulinemia, and insulin-dependent diabetes mellitus. Patients with this abnormality may have planar xanthomata in the palm creases, tubo-eruptive xanthomata, occasionally tendinous xanthomata, and arcus senilis. This abnormality is associated with premature atherosclerosis.

The dietary treatment of Type III hyperlipoproteinemia involves restriction of both caloric and cholesterol intake. The cholesterol should be limited to 300 mg or less daily and polyunsaturated fats should be used, similar to a Type II diet. After cholesterol has reached normal levels, a diet containing approximately 300 mg cholesterol daily with 40 per cent of the calories derived from carbohydrate and 40 per cent from fat may be instituted. Alcohol intake should be limited.

Dietary management of this lipid abnormality is generally successful. However, occasional patients will require the addition of a lipid-lowering agent, and clofibrate is the drug of choice. Nicotinic acid has also been effective in some patients, but cholestyramine is not useful in treating this abnormality.

Type IV Hyperlipoproteinemia (Hyper-Pre-Beta-Lipoprotcinemia). Type IV hyperlipoproteinemia is probably the most common of the lipid abnormalities. It is manifested by elevation of VLDL, rich in endogenously synthesized triglyceride. As increase in synthesis of triglyceride is frequently related to carbohydrate intake, this is sometimes termed carbohydrate-induced hyperlipidemia. Triglyceride levels are increased, occasionally as high as 2000 mg per cent. Cholesterol is usually normal but may be moderately elevated. The electrophoresis shows a densely staining pre-beta band. Standing serum is turbid and an overlying cream layer is not seen.

These patients are frequently obese. If the triglycerides are high, lipemia retinalis, eruptive xanthomata, arcus senilis, and hepatosplenomegaly may be present. Secondary types of this abnormality are many, and include diabetes mellitus, hypothyroidism, nephrotic syndrome, pancreatitis, acute and chronic alcoholism, dysglobulinemia, autoimmune diseases, and Werner's syndrome.

There is usually an excellent response to diet. It is extremely important that patients obtain ideal body weight, this alone frequently completely reversing the lipid abnormality. After attainment of ideal body weight, carbohydrate intake should be restricted to less than 50 per cent of the total caloric intake. Cholesterol should be restricted to less than 500 mg daily and polyunsaturated fats should con-

stitute a considerable part of the fat intake. Alcohol intake should be limited.

Drug therapy for type IV hyperlipoproteinemia is generally not necessary. If, after obtaining normal body weight and restricting carbohydrates and alcohol for at least six weeks, the triglyceride concentration is still above 300 mg per cent, a trial of clofibrate or nicotinic acid may be indicated. It should be re-emphasized, however, that drug therapy is only an addition to dietary management and is not a substitute. Cholestyramine and other agents are not effective in this disorder.

Type V Hyperlipoproteinemia. In this lipid abnormality both chylomicrons and VLDL are elevated, cholesterol being 250-400 mg per cent and triglycerides reaching 500 mg per cent. The electrophoresis shows dense staining of the chylomicron, beta, and pre-beta bands. Standing plasma shows a creamy chylomicron layer with a turbid infranatant.

This relatively uncommon lipid abnormality is probably transmitted as an autosomal recessive. Patients are usually obese. Pancreatitis or recurrent abdominal pain may be seen, and other manifestations of high triglycerides occur, including lipemia retinalis or eruptive xanthomata. Secondary forms of this abnormality may occur in diabetes mellitus, nephrotic syndrome, pancreatitis, alcoholism, dysglobulinemia, autoimmune diseases, and hypothyroidism.

Dietary control of Type V hyperlipoproteinemia is sometimes difficult, as patients are sensitive to both exogenous fat and carbohydrate. Maintenance of ideal body weight with a high protein, low fat, low carbohydrate diet seems to offer the best chance of success. Alcohol should be restricted. When drug therapy is indicated, nicotinic acid is usually the most effective. However, because of its frequent side effects and complications, it may be necessary to withhold nicotinic acid and try clofibrate.

Simplified Diagnosis of Lipid Abnormalities. Although precise classification of lipoprotein abnormalities may require electrophoresis or ultracentrifugation, helpful information can be obtained simply by measuring cholesterol (C) and triglyceride (TG) and examining the serum after it has been stored overnight in a refrigerator. In addition, estimation of the LDL concentration may be calculated from the equation $LDL = C - TG/5 + 45$. This is helpful in separating Type IIb and Type IV hyperlipoprotein abnormalities, which may be similar in cholesterol and triglyceride concentration and plasma appearance. It is also helpful to determine the ratio of C to TG. The following combinations of lipid abnormalities may be seen.[1]

High cholesterol and normal triglyceride. This usually indicates Type IIa hyperlipoproteinemia. The plasma C/TG ratio is always greater than 1.5 and standing plasma is clear.

High cholesterol and moderately elevated triglyceride (150-400 mg per cent). This may be seen in patients with Type IIb, III, or IV lipoprotein abnormalities. In Type IIb, the standing plasma is usually clear, sometimes faintly turbid, and a chylomicron layer is not seen. Standing plasma in Type III is usually turbid and frequently has a faint cream layer. Standing plasma in Type IV is either clear or turbid and has no overlying cream layer. Thus, examination of the plasma is not particularly helpful in distinguishing types in patients with this combination of triglyceride and cholesterol abnormality. However, it is helpful to use the formula to estimate LDL concentration. If the LDL level is elevated, it is likely that the patient has Type IIb. If the LDL level is normal or low, then Type III or IV is likely. If chylomicrons can be seen, then a Type IV abnormality can be excluded. In some cases ultracentrifugation may be necessary to exclude Type III abnormalities.

Cholesterol high; triglyceride 400-1000 mg per cent. These patients are usually either Type III, IV, or V. If examination of the standing plasma reveals no chylomicron layer, then Type IV is likely. If there is a chylomicron layer, then Type III or Type V may be present. Type III abnormalities should be suspected when the C/TG ratio is approximately 1; the C/TG ratio in Type V is usually between 0.15 and 0.6. More precise laboratory tests may be necessary to separate these abnormalities.

Cholesterol high; triglyceride greater than 1000 mg per cent. These patients may have either Type I or Type V, usually Type V. In Type I, the standing plasma shows a chylomicron cream layer over a clear infranatant; in Type V, the chylomicron layer overlies a turbid infranatant. The C/TG ratio is usually less than 0.2 in Type I, and a ratio of less than 0.1 occurs only in Type I. The C/TG ratio in Type V is usually between 0.15 and 0.6.

Cholesterol normal; triglyceride high. This is almost always Type IV. A normal level of estimated LDL helps to confirm the diagnosis. Occasionally, patients with Type III hyperlipoproteinemia will have normal cholesterol with elevated triglycerides; in this situation electrophoresis may be helpful.

LIPID LOWERING DRUGS[4]

Clofibrate. Clofibrate (Atromid-S) decreases the synthesis and enhances the catabolism of VLDL, causing triglyceride to fall. The level of LDL is generally unchanged; thus, the effect on cholesterol is minimal. Side effects are infrequent, but include nausea, diarrhea, weight gain, alopecia, leukopenia, agranulocytosis, polymyositis, and elevation of CPK and SGOT. Clofibrate potentiates the effectiveness of warfarin (Coumadin), necessitating alteration of the dose of this anticoagulant drug. Its primary indication is the treatment of Type III hyperlipoproteinemia, although it may have occasional use in Types IIb, IV, or V.

Cholestyramine. Cholestyramine (Questran) is a resin which interrupts the enterohepatic circulation of bile acids, increasing cholesterol catabolism and LDL removal from plasma. As a result, this drug is effective in lowering serum cholesterol and is the drug of choice for Type IIa hyperlipoproteinemia. It is not indicated in conditions manifested by elevated triglyceride, which it may actually elevate in some cases. Side effects include constipation, which usually is easily managed with laxatives. Other problems include nausea, vomiting, abdominal distention and cramps, and interference with the absorption of many drugs, including thiazides, digitalis, and warfarin. Although fat malabsorption may occur, fat-soluble vitamin deficiency is rare and may be avoided with appropriate supplementation.

Nicotinic Acid. Nicotinic acid decreases the production of VLDL and LDL, lowering both cholesterol and triglyceride. Its primary use is in patients with increased levels of VLDL, although ILDL and LDL may be lowered. This is an effective drug, although troublesome side effects occur frequently. Intense cutaneous flushing and itching, nausea, vomiting, diarrhea, hyperpigmentation, and abnormal liver function tests may be seen. Glucose intolerance and hyperuricemia limit its usefulness in states associated with these abnormalities.

Dextrothyroxine. D-thyroxine increases the metabolism of LDL and lowers cholesterol. Its effectiveness in lowering triglyceride has not been fully evaluated. Side effects include glucose intolerance, abnormalities of liver function tests, and neutropenia. The effect of warfarin is increased. Most importantly, d-thyroxine may produce an increase in morbidity and mortality in coronary artery disease and at the present time must be considered contraindicated in those patients. ★★★

2500 N. State Street (39216)

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"What's wrong?" cried the wife when her husband bellowed from the bathroom.

"My razor—it won't cut."

"Don't be silly," she responded, "your beard can't be tougher than the linoleum."

—*N. Miss. Medical Center News*

Sick Sinus Syndrome

KENNETH R. BENNETT, M.D.
Jackson, Mississippi

RECOGNITION OF THE individual with Stokes-Adams seizures or symptoms due to a chronically low cardiac output in association with high grade atrio-ventricular block is now commonplace. It is less well appreciated that an identical clinical picture may occur as the result of sinus node disease. Sinus node disease in such an instance is usually manifested by chronic sinus bradycardia with or without periods of more profound slowing due to sinus node failure or sino-atrial block without an attending rescue rhythm from a lower pacemaker. This results in circulatory stagnation sufficient to produce transient, but occasionally fatal, cerebral ischemia.

The traditional view of sinus bradycardia has held that it is relatively benign and of no real significance provided the individual appears well and lucid. It is now quite clear that this view is not entirely correct and that sinus bradycardia should be considered a red flag signifying the need for a more critical appraisal of the patient. The primary purpose of this paper is to show the need for a critical approach to sinus bradycardia and review the management of sinus node dysfunction.

ILLUSTRATIVE CASES

Patient No. 1 (see Figure 1)—NW, a 74-year-old white woman, had a three year history of "little strokes." When seen by her physician she always had a sinus mechanism with a rate of 50-60 per minute. A 10 hour portable tape record of her electrocardiogram demonstrated the cause of her "little strokes"; periods of marked bradycardia due to probable sino-atrial block were demonstrated. In addition, runs of tachycardia were recorded. A permanent pacemaker was inserted and she had no further difficulty.

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Presented in part at the 106th Annual Session, Mississippi State Medical Association, May 6-9, 1974, Biloxi.

Patient No. 2 (see Figure 2)—JL, a 50-year-old white man, experienced angina pectoris, "black-outs," and paroxysmal atrial fibrillation. A routine electrocardiogram demonstrated sinus bradycardia with a marked "sinus arrhythmia" unrelated to respiration. A continuous tape record demonstrated the cause for the "black-outs," sinus arrest following a run of an ectopic atrial mechanism. The patient refused a pacemaker and has been lost to follow-up.

The author wishes to show the need for a critical approach to sinus bradycardia. He presents four illustrative cases and reviews the management of sinus node dysfunction.

Patient No. 3 (see Figure 3)—OS, a 63-year-old black woman, when seen by her physician was hypotensive and disoriented. An electrocardiogram (strip A) demonstrated ventricular tachycardia or a subjunctional mechanism with aberrant conduction. She was admitted to the hospital and found to have an atrial rate (strip B) of 300 per minute. High-grade atrio-ventricular block was present and the ventricular rate was 42. She was not receiving digitalis. A short time later (strip C) marked sinus bradycardia was noted and she became hypotensive and disoriented again. A permanent pacemaker was inserted with control of the bradycardia. She continues to have episodes of tachycardia but these have been easier to manage with propranolol and digitalis without fear of prompting bradycardia.

Patient No. 4 (see Figure 4)—IH, a 36-year-old black woman with "black-outs," was found to have a sinus bradycardia with periods of sinus arrest and AV nodal (junctional) escape rhythm at 31 per minute. A pacemaker successfully prevented further "black-outs."

DISCUSSION

Asymptomatic sinus bradycardia (defined as a sinus rate below 60 per minute) is common. It is particularly common in youth and is a characteristic of the well-conditioned athlete. Asymptomatic sinus bradycardia is a common finding during convalescence from certain febrile illnesses, in patients with myxedema and obstructive jaundice, and frequently accompanies elevation of the cerebral spinal fluid pressure. It is not at all uncommon in elderly individuals and the evidence suggests that it is largely due to increased vagal tone.[1]

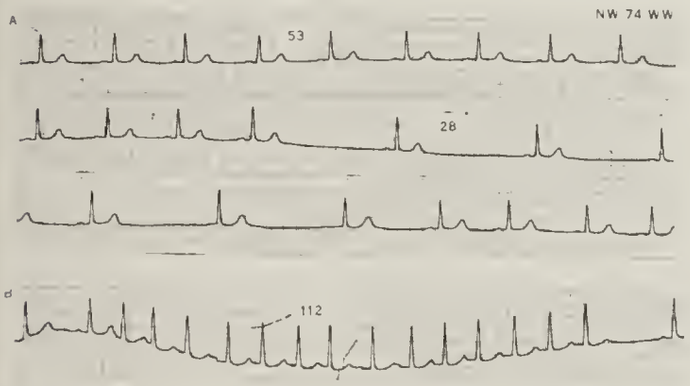


Figure 1. (A) Continuous record—Top strip demonstrates sinus bradycardia with low amplitude P waves. In the center strip the heart rate drops to approximately ½ of previous sinus rate indicating probable 2:1 sino-atrial block. (B) Run of premature atrial contractions beginning with third beat.

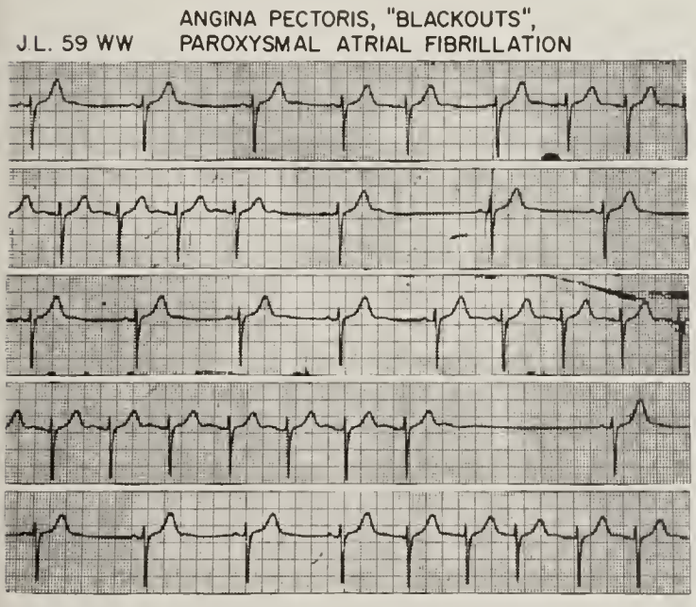


Figure 2. Continuous record—Basically there is sinus bradycardia with marked variation of sinus rhythm. Paroxysms of faster sinus rhythm are present which are followed by delay in sinus node recovery (fourth strip).

Sick Sinus Syndrome by definition implies sinus node dysfunction, but as will be evident later, the term "sick sinus" is too restrictive since patients with sinus node dysfunction quite often have dysfunction of the atrio-ventricular node as well as various ectopic atrial arrhythmias. The term was first used by Lown[2] during his early work with electrical reversion of arrhythmias to describe patients with chronic atrial fibrillation who demonstrated either tardy return of sinus activity and/or marked sinus bradycardia following electrical reversion. In addition, these patients frequently demonstrated chaotic atrial activity with runs of atrial or nodal tachycardia following electrical reversion. There are many synonyms for this condition; lazy sinus,[3] sluggish sinus,[4] and sino-atrial syncope.[5] In addition to bradycardia, many individuals show a marked tendency to bouts of tachycardia alternating with bradycardia (Patient No. 3). This paradox has been called the bradycardia-tachycardia syndrome.[6]

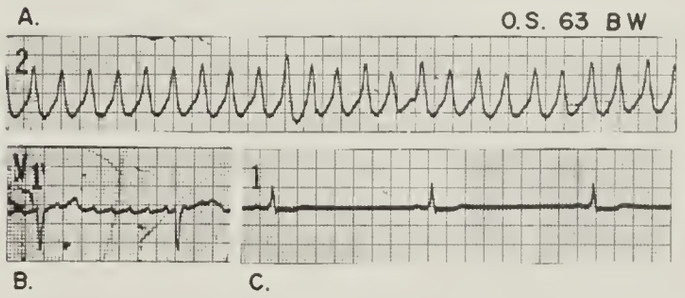


Figure 3. (A) Subjunctional supraventricular tachycardia with aberrant ventricular conduction vs ventricular tachycardia is present. (B) After cessation of the tachycardia atrial flutter with high-grade AV block is noted. (C) Following reversion, a slow sinus mechanism is present.

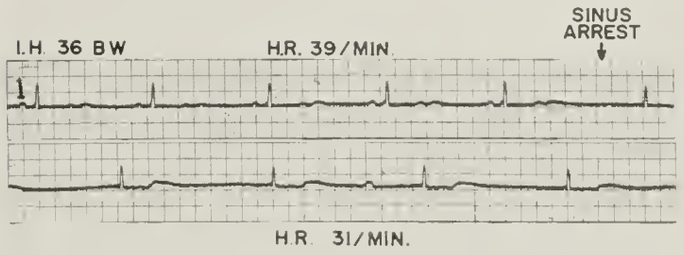


Figure 4. A sinus bradycardia with sinus arrest is noted. An abnormally slow AV nodal escape rhythm at 31/minute takes over.

In patients with sick sinus syndrome three features stand out. First, there is sinus node dysfunction which is manifest by chronic sinus bradycardia of

a moderate degree with or without episodes of more profound sinus slowing due to sinus arrest or sino-atrial block. Secondly, there is often an associated atrial disorder (premature atrial contractions, atrial tachycardia, flutter, or fibrillation) and occasionally ventricular ectopy is noted. Lastly, there may be evidence of atrio-ventricular node dysfunction (depressed escape impulse discharge rate and/or depressed conduction). Why there should be multiple sites of involvement is not altogether clear but it is nonetheless fact. The most probable explanation is that there is a common susceptibility to the embryonically similar neuromuscular tissue of the sinus node, atrial and atrio-ventricular node to the particular disease process.

Most patients are beyond middle age but there are many exceptions. The symptoms are quite variable and range from lethargy to syncope or even fatal convulsions. Symptoms generally fall into three groups. Any given individual may exhibit features of any or all three groups.

I. *Low Cardiac Output Symptoms:* these patients are lethargic, lacking in vigor, and may complain of dyspnea and/or difficulty with sleeping, memory, or appetite. Chronic sinus bradycardia is the usual underlying problem.

II. *Acute Cerebral Symptoms:* episodic fainting, dizziness, disorientation, visual disturbances are quite typical. The underlying mechanism is a sudden marked bradycardia as a consequence of a sinus arrest or sino-atrial block.

III. *Symptoms Related to Tachycardia:* these are also quite variable and range from palpitation to prostration as a result of the heart's inability to maintain an adequate stroke volume because of tachycardia. Not infrequently at the termination of tachycardia (which is often paroxysmal) a long period of asystole results in a syncopal spell.

Failure to consider sinus node dysfunction is common for several reasons. These individuals are likely to be elderly and are thought to be suffering from transient ischemic attacks or senility. Since many individuals are of such an age that bruits over the carotid arteries are not at all uncommon, extracranial vascular disease is diagnosed. Coexisting cerebrovascular disease is not unusual and many patients may have symptoms on this basis alone.

The patient's heart rate is often in the range of 50 to 60 per minute when seen by a physician and because of the traditional view of the relatively benign nature of sinus bradycardia it is often not considered significant. It is the patient who has paroxysms of tachycardia that alternate with bradycardia who has been the most difficult one to handle. Often the symptoms from tachycardia are so pronounced that the physician completely ignores the bradyarrhythmia which dominates the inter-tachycardia periods. An attempt to control the tachyarrhythmia treatment with drugs such as digitalis or propranolol, both of which have profound effects on the sinus rate, may aggravate the bradycardia.

A typical patient might demonstrate sinus bradycardia (sinus node dysfunction) with very little in the way of symptoms except for mild apathy. Sinus arrest may occur without the appearance of a rescue rhythm in the A-V node (A-V node dysfunction), resulting in syncope. Atrial ectopy in the form of premature beats, flutter, or fibrillation is seen frequently. In the case of a sustained supraventricular tachycardia the depressed A-V node conducting ability results in a lower than expected ventricular rate. In some instances sudden cessation of a paroxysmal tachycardia is followed by a delay in sinus recovery sufficient to produce circulatory stagnation. Obviously, one would expect a rescue rhythm in the A-V node to prevent such an occurrence but since A-V node dysfunction is often present such an unfortunate situation is not at all uncommon.

Diagnosis is based on a high degree of suspicion and confirmed by demonstrating that sinus node dysfunction is responsible for or capable of producing the symptoms. Obviously, an individual can have sinus bradycardia and be perfectly well. It also follows that an individual can have sinus node dysfunction and symptoms of cerebral disease on an entirely separate basis. Fortunately, in the majority of patients it is not too difficult to demonstrate a cause and effect relationship once suspicion is aroused. Monitoring the patient's electrocardiogram on a long term basis either by a tape recorder such as the Holter system or in a hospital setting, is usually adequate to demonstrate the offending rhythm disorder. It is often worthwhile to enlist the aid of those close to the patient so that they might observe the attacks, check the pulse during such spells or during sleep.

Several pharmacologic and electrophysiologic tests have been used to demonstrate sinus node dysfunction. These tests are of occasional help but are not so reliable that they are considered necessary in the usual patient.[7]

The routine resting electrocardiogram can often be of tremendous help in spotting such patients. The following are electrocardiographic clues:

1. Sinus bradycardia with or without: (a) Atrial ectopic activity (PAC's, tachycardia); (b) Sinus arrest; (c) Sino-atrial block; (d) "Sinus arrhythmia" in the elderly; (e) AV block; (f) Low amplitude or notched P waves.

2. A-V nodal rhythm with rate less than 60.

3. Unusual suppression of sinus node recovery following a PAC or at termination of tachycardia.

4. Atrial fibrillation or flutter with or without a slow ventricular response.

Sinus bradycardia is the most frequent finding and serves as the bellwether. The low sinus rate is the result of depressed sinus node discharge and/or failure of the impulse to depolarize the atria (SA block). In many instances the sinus discharge rate varies so much that sinus arrhythmia is diagnosed. Sinus arrhythmia, defined as the speeding of the sinus rate with inspiration and slowing with expiration, is common in youth but tends to be less common after middle age. "Sinus arrhythmia" in the older individual may well indicate disordered sinus function with pathologic variation in the sinus discharge rate particularly if unrelated to respiration. Such a finding should not be taken lightly.

Lown,[2] in his early observations of patients following electrical reversion, noted that those with chronic atrial fibrillation and a slow ventricular response were poor candidates for "cardioversion." This opinion was based on two findings. First, they frequently returned to atrial fibrillation after a short period, and secondly, they demonstrated a marked delay in sinus return as well as a tendency to ectopic atrial tachycardias. Conclusions cannot be drawn in every instance but many such patients fall into the sick sinus category.

The observations of Lown[2] regarding the delayed return of sinus function following conversion is the basis of our understanding of the diagnosis and management of the patient presenting with the tachycardia-bradycardia paradox. Observation has shown that the period immediately following the cessation of tachycardia is occasionally associated with fainting.[6] Some degree of tardiness of sinus recovery is normal but the degree exhibited in these individuals is excessive. Suppression of the sinus node may be observed following a single premature atrial contraction and in the normal individual usually does not exceed 25 per cent of the preceding normal sinus cycle (P-P interval). A delayed appearance of the P wave following a PAC suggests that sinus automaticity is too easily suppressed and unusually tardy. Atrio-ventricular nodal rhythm with a rate below 60 per minute implies that the fastest pacemaker resides in the A-V node. Such a finding indicates that sinus node automaticity is probably depressed.

Several causes for the loss or depression of the natural sinus rhythm have been implicated. The association of sinus node injury and dysfunction with coronary artery disease is well recognized.[8] Since the blood supply to the sinus node is by single artery arising from the proximal portion of the right coronary artery in approximately 55 per cent of individuals and from the circumflex coronary artery in the remainder, proximal stenosis of the main artery or the sinus node branch jeopardizes the blood supply to the sinus node. In an acute myocardial infarct this can be a mechanism for sudden death.[8] In a similar fashion, chronic sinus node ischemia may lead to slow degeneration. Almost every infiltrative or inflammatory disease that affects the heart has been associated with this syndrome (cardiomyopathies, collagen disorders, various forms of myocarditis, malignant invasion). Amyloid involvement of the heart is particularly notable. However, in the majority a degenerative process of unknown cause is present. The patients are usually elderly, but occasionally degenerative changes are observed in younger individuals including infants. Certain drugs, notably digitalis, reserpine, and propranolol depress sinus node function and the possible role of such drugs should be considered. However, it is well worth recalling that digitalis rarely produces profound slowing of the sinus rate and should not be considered as the sole cause.

Medical treatment is far from satisfactory and is not always necessary unless associated with significant symptoms. The sinus rate may be temporarily increased by diminishing vagal tone with atropine or stimulating sympathetic activity with a beta-adrenergic drug such as isoproterenol, but these drugs are not usually satisfactory for abolishing or preventing bradycardia due to sinus arrest or block. Effective long-term medical management is difficult to maintain and the response to therapy tends to diminish with time. Furthermore, the use of some drugs such as isoproterenol may actually incite tachycardia. When individuals suffer only from episodes of bradycardia, pacemaker management is almost always satisfactory. In those with paroxysms of tachycardia pacemaker therapy may not only con-

trol the bradycardia but also may diminish the problem with tachycardia. Some patients continue to have tachycardia despite pacemaker use, but a pacemaker does allow more aggressive treatment of tachycardia. Drugs such as digitalis or propranolol which are quite useful in preventing and controlling episodes of tachycardia may make matters worse by producing bradycardia. Therefore, in such individuals a pacemaker is the mainstay of treatment. This will control the bradycardia effectively and allow a more liberal use of these drugs without fear of aggravating the bradycardia condition.[9]

CONCLUSION

The sick sinus syndrome is an often overlooked cause of chronic low output symptoms or transient cerebral attacks. Continuous observation and monitoring may be necessary to demonstrate the offending mechanism disturbance. Once the diagnosis is made symptoms can be effectively managed with a permanent pacemaker. ★★★

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WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

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The many fine technical exhibitors who participated in the exhibit during the recent Mississippi State Medical Association 107th Annual Session are deserving of our recognition and a hearty "Thank You!" Not only did the presence of these exhibits enhance the educational quality of our meeting, but the support provided by our exhibitors is essential to the continuance of our traditionally outstanding scientific program.

The firms listed below participated in our 1975 annual meeting exhibit and we voice a collective expression of our sincere appreciation. May we also suggest that you retain this listing and express your personal appreciation when their representatives call upon you.

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Radiologic Seminar CLII: Applications of Ultrasound B Scanning in the Abdomen

KENNETH G. CARTER, M.D.
Jackson, Mississippi

ULTRASOUND B scanning produces sectional images of the abdomen with no invasion of the body surface and no radiation dose to the patient. Because ultrasound travels in soft tissue at a known speed (approximately 1540 meters per second), the images are to scale so that structures and organs and their distances beneath the skin can be measured directly from the sonogram. Ultrasound interacts with matter in such a way that fluid filled (homogeneous) structures and spaces can be differentiated from solid (non-homogeneous) soft tissue structures. Routine radiography does not have any of the above properties but, of course, is non-invasive. However, radiography and ultrasonography are quite complimentary since bone structures and air containing spaces are easily demonstrated with radiography but not possible with current ultrasonography.

Ultrasonography can be helpful in evaluating the aorta for aneurysm or dilatation, confirming the presence of renal cysts, locating intra-abdominal abscesses, detecting ascites, determining placenta location and gestational age of the fetus in pregnancy, and in many other clinical problems. A few of these will be discussed and demonstrated with sonograms. The ultrasonograms were obtained with a Picker Echoview XI with grey scale and echoes are displayed as black or grey dots on a white background. Structures or spaces composed of homogenous tissue or fluid appear echo free (white) since there are no different density tissue interfaces within these structures to produce echoes. Solid masses usually have different density tissues within so that echoes are produced, the mass appearing "speckled or grey," not echo free.

The aorta can usually be demonstrated easily whether normal or abnormal. It appears as an echo free (white) tubular structure on longitudinal scanning (see Figure 1), a circular echo free structure just anterior to the spine on transverse scanning. A

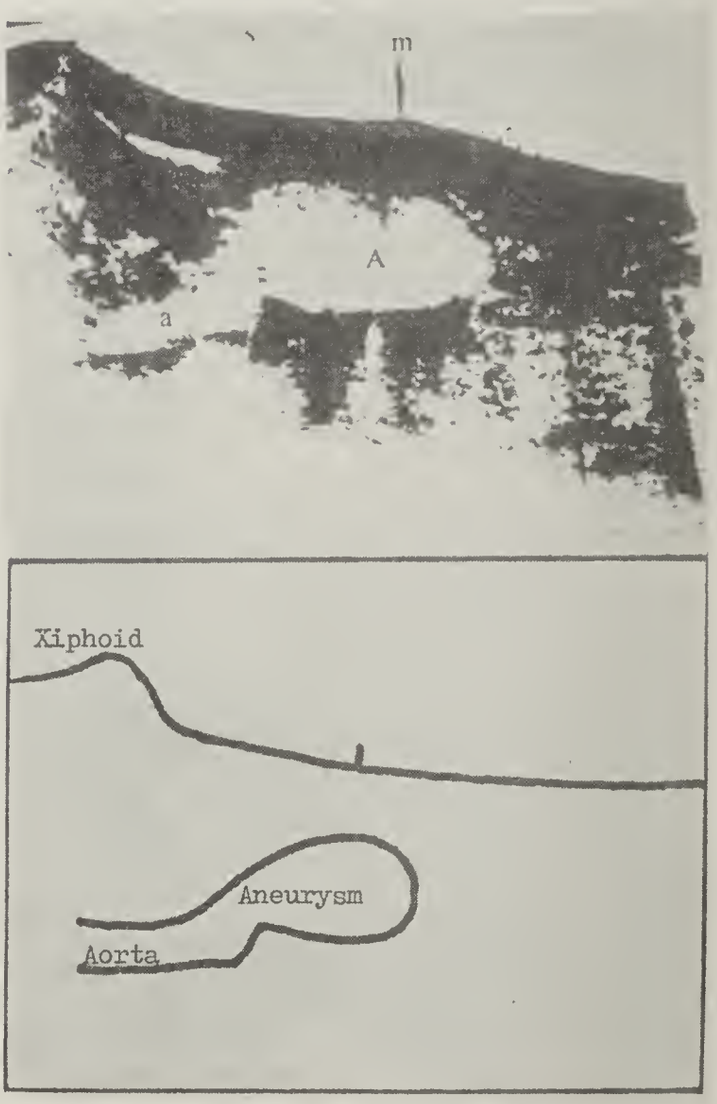


Figure 1. Longitudinal sonogram (sagittal section) through the aorta with the patient supine, head to the left. m = electronically placed marker on anterior abdominal surface at the level of the iliac crest. s = electronically placed scale, 1 cm between the dots. x = *xiphoid, a = upper abdominal aorta, A = aneurysm, approximately 13 cm in length, 6 cm in diameter.*

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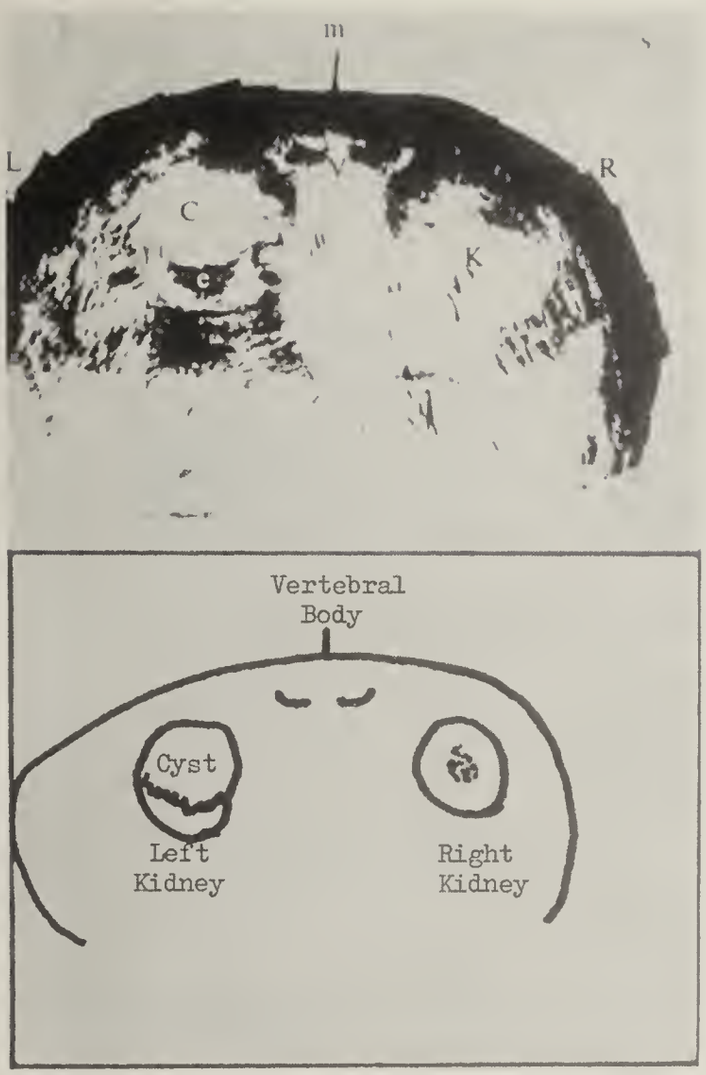


Figure 2. Transverse sonogram (cross section) through the kidneys with the patient prone. Note the echo free mass of the left kidney (C), displacing calyceal echoes (e) anteriorly. m = electronically placed marker at the midline of the back, s = electronically placed scale, 1 cm between the dots. L = the left side of back, R = the right side of the back. C = cyst, approximately 4.5 cm from posterior to anterior margins. K = normal right kidney, V = vertebral body.

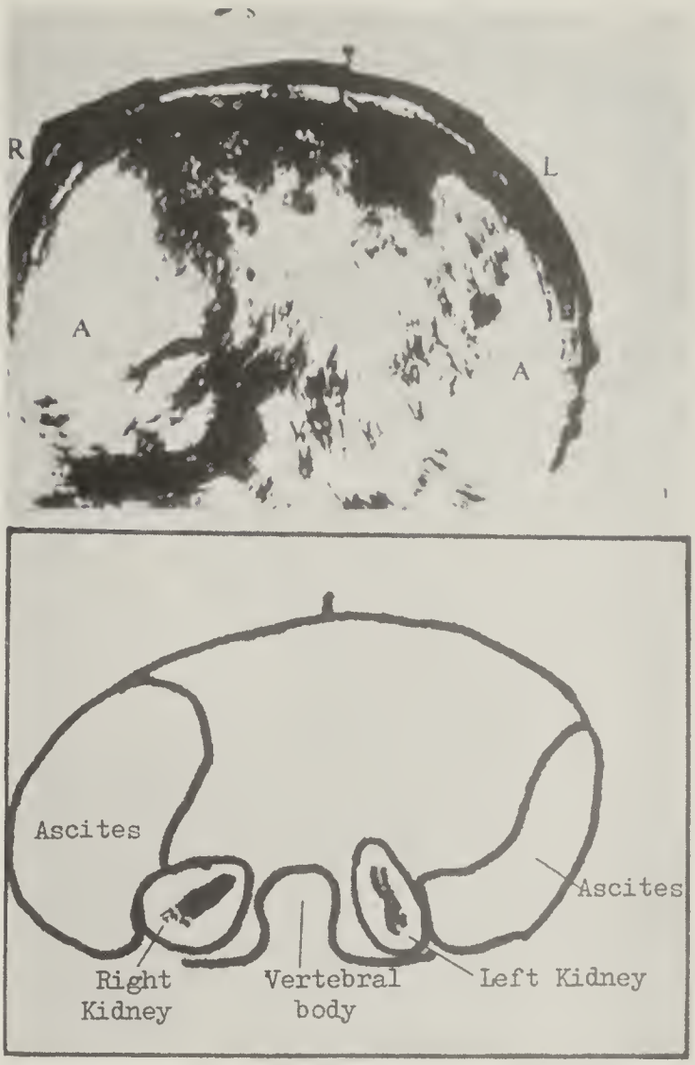


Figure 3. Transverse sonogram (cross section) through the mid abdomen with the patient supine. R = right side of the anterior abdomen, L = left side of the anterior abdomen, s = electronically placed scale, 1 cm between the dots, A = fluid (echo free) collection laterally in the flanks.

marker can be electronically placed on the image to correspond to a body landmark, such as the level of the iliac crests, to assist with orientation when viewing the sonogram. The scale marker is also electronically placed so that a structure can be measured and compared to the scale with the space between two scale dots representing 1 cm.

A renal cyst contains fluid and therefore appears as an echo free (white) mass arising from the kidney and sometimes displacing the normal pelvocalyceal echo patterns (see Figure 2). Normally the kidney is relatively echo free with central echoes produced by the interface between pelvocalyceal structures and renal parenchyma.

Figure 3 shows bilateral flank echo free spaces which are not normally present. This indicates the presence of fluid. The patient had ovarian carcinoma responsible for the ascites. If necessary to show that fluid is not loculated, repeat sonogram can be obtained with the patient rolled to one side. If free, the fluid accumulates in the dependent portion of the abdominal cavity.

In obstetrics and gynecology, ultrasonography is particularly beneficial as the sectional images can demonstrate the uterine cavity (see Figure 4) and its contents and relationship of a pelvic mass to the uterus. The fetal head size (biparietal diameter) can be accurately measured in pregnancy to assess gestational age. Since the rate of growth and size of the fetal head at various gestational ages have been determined, fetal development can be followed by seri-

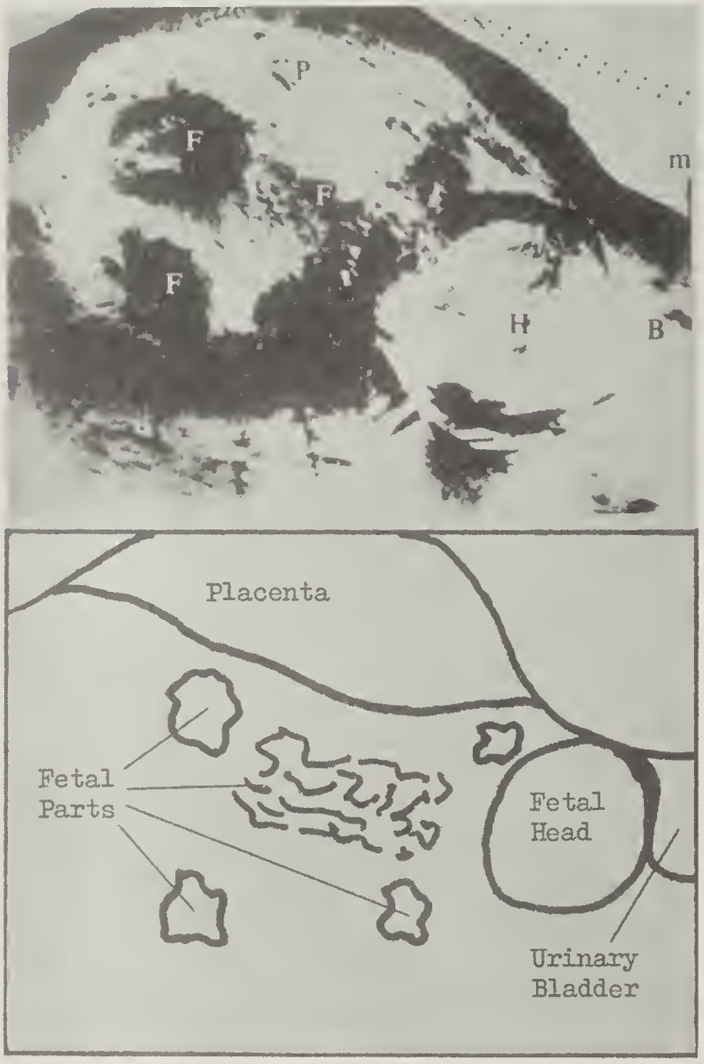


Figure 4. Longitudinal sonogram (sagittal section) through the midline of the abdomen in a pregnant patient lying supine. m = electronically placed marker at the pubic symphysis. B = urinary bladder, H = fetal head, F = fetal parts and P = placenta.

al ultrasonography, there being no radiation dose to the fetus or mother. Also the placenta can be identified, its location in the uterus determined and the amount of amniotic fluid assessed.

The role of abdominal B-ultrasonography in cyst or fluid aspiration, radiation therapy, evaluation of the pancreas, retroperitoneal masses, liver and gallbladder could not be discussed in this brief summary. Ultrasound can provide information not available by routine radiography and the interest and uses of this modality will likely increase greatly over the next few years. ★★★

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Otto F. Eisenhardt, M.D.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

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The President Speaking

"The 107th Annual Session"

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

ONLY THE INCLEMENT weather and a few minor annoyances related to sound and projection equipment marred the recent 107th Annual Session. The scientific sessions were excellently planned and magnificently executed. The reference committees handled their business with skill and dispatch and the delegates demonstrated an earnest and honest desire to seek ways and means of resolving the many significant issues which confront the medical profession in general and the Mississippi physicians in particular. It was obvious from the discussions in the reference committees and from the debate on the floor of the House of Delegates that we do not all agree on the precise manner in which these issues are to be addressed. That is to be expected. Only zealots and children see complex and important issues with great clarity. The rest of us must cope with conflicting feelings and directions and make important decisions armed with truth as we see it.

In our days we see institutions that get their ends confused with their means, institutions that forget the people they are created to serve and become concerned only with their own survival. I was impressed, as I am impressed each year when attending our Annual Session, that the Mississippi State Medical Association is not a union of self seeking doctors but a service organization seeking ways and means to continue to render the highest quality medical care possible to the two million Mississippians we are privileged to serve. As long as that continues to be our ultimate goal, I am confident means will continue to be devised to attain it. ★★★

JOURNAL OF THE
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MEDICAL ASSOCIATION

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EDITORIALS

The Development of Nuclear Power

Most of us are now painfully aware of the fact that our fossil fuels, other than coal, have almost been exhausted. While there are other sources of energy such as hydrogen, sunlight, wind, etc., which are potentially much better than oil and gas we have not yet developed a technology that would enable us to put them to practical use on a large scale.

As we look to the immediate future, the one source of energy that *can* be tapped to partially meet our insatiable demands is nuclear energy. Though it can never be expected to supply more than a small percentage of our total needs, the prospects of doing without it are so bleak that some segments of society have become impatient with the fears expressed by others. In a recent letter to the Jackson, Mississippi, *Clarion Ledger,* one writer voiced the opinion that we should stop arguing the point and "get on" with the development of nuclear power.

Maybe so, but before we do we ought to be certain that we understand some of the risks involved.

We are all exposed to low levels of "background" radiation that reach us from outer space and from fissionable materials in the earth's crust. We have no protection from this exposure and we do not know how important it may be in the etiology of malignancies and genetic mutations which occur without explanation in humans and other animal species. But we cannot add to this radiation without incurring additional risks. Ionizing radiation, in any amount, is harmful to biological systems. That is to say, there is no practical threshold value below which no damage occurs. The damage is generally proportional to the amount of radiation and may be so slight that it cannot be detected in the generation in which it occurs, if ever, but it is there nonetheless. Presumed "safe" limits of exposure to varying kinds and levels of radiation have been established but they are largely discretionary and are based principally upon damage that can be detected. They cannot take into account the time lag between the initial exposure and the appearance of detectable effects.

Many people seem to fear that nuclear reactors are dangerous because they might conceivably "go critical" and explode or melt themselves down. The likelihood of this happening is so remote that the risks involved can probably be accepted, for explosion is not the greatest danger. On the other hand, the handling, transportation and storage of nuclear wastes that must be removed periodically from reactors may constitute hazards the importance of which cannot be over-emphasized.

Reactor wastes contain mixtures of fissionable materials some of which are relatively harmless. Others, however, are deadly even in extremely small amounts and some have half lives so long that they can be expected to be a problem for as long as human life continues on earth. Dr. Edward Teller, often referred to as "The Father of the Atomic Bomb," recently told a governor's conference in Jackson that these radioactive wastes would for all practical purposes have to be monitored "forever."

Forever is a long time! And up to now we have not done very well with regard to sealing up and keeping out of our environment the wastes we have already produced. The undersigned is an official observer of the Smithsonian Institution and, as such, receives reports of physical and biological phenomena reported to the Smithsonian. It is worthy of note that *in the calendar year 1974 alone,* seven (7) instances of radioactive waste leaks and/or "excessive" radioactive gas release from waste storage facilities and nuclear reactors were reported. Some were de-

tected early and were relatively unimportant, but several were potentially devastating. Examples:

(1) On Mar. 14, 1974, about 2,500 gallons of "highly radioactive liquid waste" leaked out of a storage tank on the AEC's Hanford reservation in the state of Washington.

(2) On June 8, 1974, 115,000 gallons of "highly radioactive" waste leaked into the ground at the Hanford storage facility north of Richland, Washington. Ground water in this area gradually seeps into the Columbia River seven miles away.

(3) On May 3-4, 1974, between 500 and 2,000 gallons of radioactive waste leaked into the ground from storage tank No. 111SX at the Hanford storage facility. This waste contained strontium^{90} and cesium^{137}.

(4) On Sept. 3, 1974, "several hundred gallons of radioactive waste water spilled from a "manhole" at Los Alamos, New Mexico.

(5) On Oct. 1, 1974, cracks were found in "the cooling system bypass pipes" of two reactors in Illinois and one in Connecticut. This prompted the AEC to order a shutdown of all similarly constructed reactors for inspection.

(6) On Oct. 18, 1974, radioactive gas in amounts exceeding the AEC's limit escaped from a power plant in Cordova, Illinois.

(7) On Dec. 20, 1974, cracks were discovered in the cooling system piping in a reactor in Morris, Illinois.

A principal fuel of nuclear reactors is uranium^{235}, with a half life of 710 million years. One of the most important substances produced in reactors from natural uranium is plutonium^{239}, which has a half life of 24,000 years. Cesium^{137} and strontium^{90} have half lives of 30 and 28 years respectively but, when ingested, strontium^{90} is metabolized in the human body in exactly the same way as calcium. It is deposited in the bones where it produces internal radiation for much longer than the victim will live. Plutonium^{239} is one of the most potent carcinogens known.

In working with these and other highly radioactive substances, for whatever reason, we are quite literally bringing into our environment (and, in some cases, turning loose in our environment) primeval forces which if they had been here all the time would have precluded the development of life as we know it. We are gradually but surely contaminating our ecosystem with substances that we know will have to be contained and monitored throughout all the future of the human race. This is a challenge that is without precedent in the history of man, for if we should one day discover that we cannot *really* protect ourselves from these substances it will be far too late to do anything about it. The record last year and in previous years testifies to the fact that we have not been able to keep these waste products out of our environment, and the evidence strongly suggests that we probably cannot. We may be making a mistake from which there can be no retreat.

Thomas J. Brooks, Jr., M.D., Ph.D.
Professor and Chairman
Department of Preventive Medicine
University of Mississippi Medical Center

Medico-Legal Briefs

NO NEGLIGENCE IN FAILURE TO DIAGNOSE APPENDICITIS IN CHILD

A physician's diagnosis of gastroenteritis in a child who was later found to have a ruptured appendix was not negligent, a federal trial court in Mississippi ruled. The court found that the original diagnosis was compatible with all of the symptoms and that negligence was not be to presumed solely because of untoward results.

On the afternoon of Aug. 22, 1971, the 10-year-old child had a stomachache and vomited. Fever and diarrhea developed that night, with cramping, intermittent stomach pains.

When a physician saw the child on the following morning, he had a temperature of 101°F. The physician noted a dark green loose stool, hyperactive bowel sounds and generalized abdominal tenderness but no rebound pain. The abdomen was mildly protruding but not rigid.

The physician's impression was that of acute infectious, or bacterial, gastroenteritis, which he had seen in a number of children. He prescribed Terramycin for the infection and Phenergan suppositories to alleviate nausea.

The child's condition worsened that night, and the physician arranged for his hospitalization at 5:15 a.m. At that time he had nausea and diarrhea and was vomiting, with 101°F. temperature and 100 pulse rate. He was given a Plasmylite drip with vitamins and an injection of Phenergan. The physician ordered a complete blood cell count and urinalysis. The nurses' record showed that there had been no vomiting an hour after admission.

At 8 a.m., the physician found the child's con-

dition essentially the same as 24 hours earlier. He continued with the diagnosis of gastroenteritis, although he considered appendicitis, among other possibilities. There was no rebound pain or localized abdominal tenderness. The physician ordered Polycillin for the infection and Dramamine for nausea.

The child's white blood cell count was 18,592. His temperature and pulse improved, but his bowel sounds remained hyperactive and there was generalized abdominal tenderness. A second reading showed 16,812 white blood cells.

On the second day of hospitalization, there was no localized or rebound pain. The abdomen continued to be soft and nonrigid, with no distention. By evening, the child showed considerable improvement.

By 1 a.m. on the third day, the child's condition had worsened. He vomited a large amount of bile and complained of abdominal pain. The hospital record showed that the abdomen was distended for the first time.

When the physician examined the child at 8 a.m. he found a distended, rigid abdomen, severe generalized abdominal tenderness, and no bowel sounds. He requested immediate consultation with a general surgeon.

The surgeon ordered x-rays, which showed marked distention of the small bowel with air fluid levels. The surgeon thought that the child had a perforated appendix with abscess formation and small bowel obstruction, as well as probable severe peritonitis.

The child was regarded as a poor surgical risk, but the surgeon decided that immediate exploration was necessary. At surgery, the appendix, which was ruptured, was removed, and a large amount of pus was drained from the abdomen.

Although the patient was treated with large doses of Keflin, his temperature remained at 103°F., he was disoriented, and he remained critically ill. The surgeon performed a second operation 3 days later, when the child's abdomen failed to decompress naturally.

After the second operation, the patient's condition steadily improved. Then postoperative complications developed, including esophageal bleeding caused by ulcerations from insertion of a Levine tube. Esophageal structure required dilation, and a stenosis present four months later was expected to remain for an indeterminate period.

The child's father brought an action for malpractice against the physician.

At the trial the surgeon testified that it was advisable for general practitioners to promptly refer children for surgical consultation in all cases where there was abdominal tenderness. Although he felt that general practitioners were competent to diagnose appendicitis, he feared that giving medicines such as pain-killers might mask symptoms and make the diagnosis more difficult.

The surgeon said that if the child had been referred to him earlier the most likely diagnosis, considering the child's age, would have been appendicitis. He conceded that if the child had been suffering from gastroenteritis the course followed would be acceptable medicine.

All of the other medical testimony directly contradicted the surgeon's opinions. Two highly qualified surgical specialists said that acute infectious gastroenteritis was the correct working diagnosis and that the course of treatment was proper.

One of the specialists said that the child probably had gastroenteritis at first and that acute appendicitis developed secondary to the infection. Both said that this was a rare and unusual case of appendicitis.

The surgeon said that if x-rays had been taken earlier they probably would have aided in diagnosing appendicitis. The other medical witnesses disagreed sharply, saying that x-rays were usually of no diagnostic aid in appendicitis.

The court found that the issue of fact raised by the surgeon's testimony was rebutted by the testimony of the physician and the other medical witnesses. X-rays taken earlier would have been of doubtful value and of no aid in diagnosing appendicitis, the court said.

The court also found that it was within the competence of general practitioners and pediatricians to diagnose appendicitis and that it was not standard medical practice to automatically refer children wih only abdominal pain or tenderness to a surgeon. Such automatic referral was not only unrelated to adequate medical care but would impose intolerable burdens on surgeons.

The court held that the child's symptoms presented a typical case of gastroenteritis and did not suggest the likelihood of appendicitis and that the physician had provided adequate medical care. It was a reasonable medical probability, the court said, that appendicitis developed secondary to the gastroenteritis and that the appendix ruptured and became gangrenous not more than 10 hours before the first operation.

Holding that no physician was a warranter of cures, the court concluded that the child's father had failed to establish negligence and denied recovery of damages.—*Hawkins v. Ozborn,* 383 F.Supp. 1389 (D.C., Miss., Sept. 6, 1974)

PERSONALS

O. J. Andy of Jackson and UMC presented a paper on "ethics in the psychosurgical modification of abnormal behavior" at a symposium on behavioral control, psychosurgery, and the patient's rights in Orlando, Fla.

James F. Arens of Jackson and UMC was guest lecturer for the Virginia Society of Anesthesiologists meeting in Richmond in April.

Thomas Barnes of Greenville recently took a working trip to St. Croix Hospital in Haiti.

Benjamin E. Box has associated with the Lindley-Jones Clinic for Women, P.A., at 1410 20th Avenue in Meridian for the practice of obstetrics and gynecology.

Richard Burman of Gulfport and Guy Campbell of Jackson were appointed by MSMA to be advisors to the American Association of Medical Assistants, Mississippi Society, and Rita Heidisch of Gulfport was elected association advisor for the coming year.

Kanta P. Butani announces the opening of her pediatric practice at 1213 Magnolia Avenue in Tylertown.

Elmo P. Gabbert of Meadville has received the AMA "Physicians Recognition Award" for 1974-77.

Robert L. Forman of Clarksdale received a plaque commemorating his many years of service to the medical community from the Board of Directors of the Northwest Mississippi Regional Medical Center and from Clarksdale and Six Counties Medical Society.

Richard F. Gates of Gulfport was honored with a reception at Gulfport Memorial Hospital upon his retirement after a 41-year medical career.

John Y. Gibson of Jackson and UMC took a diagnostic ultrasound course at Episcopal Hospital in Philadelphia, Pa.

James D. Hardy of Jackson and UMC gave the Hale-McMillan Lecture on support of the critically ill surgical patient at Meharry College in Nashville.

Glyn R. Hilbun of Moss Point has been appointed by Gov. Bill Waller to the Mississippi Offshore Terminal Advisory Council.

Wendell Holmes of McComb reigned as king of the annual Junior Auxiliary Azalea Ball.

James McQueen, Robert Abraham, and Joe Weldy of Vicksburg are serving on the American Cancer Society board of directors.

Richard C. Miller of Jackson and UMC was program moderator for the American Pediatric Surgical Association meeting in San Juan, Puerto Rico.

Francis S. Morrison of Jackson and UMC was elected district director of the South Central Association of Blood Banks at the group's meeting in New Orleans.

Joe R. Norman of Jackson and UMC addressed the East Mississippi Medical Society meeting in Meridian on "potent glucocorticoids in obstructive lung syndrome."

John Pearson of Hattiesburg has been elected medical representative for 1975-76 for the Forrest County Heart Association.

Joe G. Peeler, Sr., of Shaw was honored on May 10 when the people of Shaw had "Dr. Joe Peeler Day" in appreciation for his 37 years of service as a doctor. Many former patients, babies he delivered and friends attended the event. Front Street in Shaw has been renamed Peeler Avenue.

Mario R. Pineda announces the removal of his office from State Street in McComb to Suite 301, Medical Towers, 440 East Woodrow Wilson in Jackson.

E. J. Price, Jr., of McComb announces the association of Leon Langston for the practice of obstetrics and gynecology at the Medical Arts Building, 300 Rawls Drive.

Ron Rennick announces the opening of his medical practice at 303 South Dauphine in Poplarville.

John R. Shell of Vicksburg recently attended a seminar on "recent advances in immunoprophylaxis and chemotherapy of infectious diseases" in Tucson, Arizona.

Mary B. Wheatley of Jackson announces the opening of her office for the practice of psychiatry at Suite 234, Highland Village, 4500 Interstate 55 North.

George E. Wilkerson, formerly of Gulfport, has now associated with the Hattiesburg Psychiatric Group, P.A., in the Medical Arts Building, 405 South 28th Avenue.

THE LITERATURE

Book Review

Handbook of Legal Medicine. 4th Edition. By Alan R. Moritz, M.D., and R. Crawford Morris, LL.B. 286 pages with illustrations. St. Louis: The C. V. Mosby Company, 1975. Paperback $10.25.

Judge Irving Goldstein, in the foreword of this text, stated with clarity its overall purpose "is clearly intended for ready reference rather than detailed research."

The fourth edition of the *Handbook of Legal Medicine* (the first edition was a classic in the field) has been updated to some extent by the authors. The book is divided into two major categories ranging from scientific medical legal investigation to physician and patient-physician and the law. The illustrations are clear and ample, the diagrams are most appropriate and the charts are comprehensive.

Some areas of the *Handbook of Legal Medicine* may disappoint its readers. These are the chapters on Abortion and Organ Transplants-Human Experimentation. Perhaps greater depth, as far as more recent events and court decisions, would be somewhat beneficial.

It seems to the reviewer that a chapter or two about the other partner in medical care—the patient—would add greater dimensions to the handbook. I am thinking of confidentiality and privacy, children and their rights, prisoners and their rights, the terminally ill, and his or her rights.

Certainly, Chapter 30 on Medical Professional Liability and Chapter 32 on The Medical Witness and His Testimony are indeed classics.

The handbook is wholeheartedly recommended to the practitioner and student with the proviso that they understand its limitations.

PAUL S. DERIAN, M.D.
Jackson, Miss.

NEW MEMBERS

BOX, BENJAMIN EDGAR, Meridian. Born Quitman, Miss., Sept. 26, 1929; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1961; interned United States Air Force Hospital, Lackland AFB, Tex., one year; ob-gyn residency, Southern Baptist Hospital, New Orleans, La., 1964-67; elected by East Mississippi Medical Society.

DELIVORIAS, LAURIN ANNE, Miss. State. Born Jackson, Miss., May 21, 1947; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1973; interned, same, one year; elected by Prairie Medical Society.

EHLERT, WILLIAM ROWE, Pascagoula. Born Selma, Ala., June 13, 1943; M.D., University of Alabama School of Medicine, Birmingham, Ala., 1969; interned Mobile General Hospital, Mobile, Ala., one year; radiology residency, same, 1970-74; elected by Singing River Medical Society.

HATTEN, LEWIS E., Hattiesburg. Born Hattiesburg, Miss., Aug. 19, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1968; interned, same, one year; general surgery residency, same, 1969-73; vascular surgery residency, same, 1973-74; elected by South Mississippi Medical Society.

MEYER, JON RAYNER, Jackson. Born Neevah, Wisc., Sept. 15, 1947; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1973; interned, same, one year; elected by Central Medical Society.

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

June 18-19, 1975

FAMILY PLANNING VASECTOMY WORKSHOP FOR PHYSICIANS

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education and the School of Medicine, Department of Obstetrics-Gynecology Division of Family Planning

POSTGRADUATE / Continued

Coordinator:
Helen B. Barnes, M.D., associate professor of obstetrics-gynecology, the University of Mississippi School of Medicine
Ms. Charme S. Davidson, consultant, the University of Mississippi School of Medicine Department of Obstetrics-Gynecology Division of Family Planning

The curriculum is designed to examine the medical, legal, social, psychological, and counseling aspects of vasectomy. No fee will be charged.

Courses offered through the University of Mississippi Medical Center Division of Continuing Health Professional Education are open to all Mississippi physicians.

FUTURE CALENDAR

September 11, 1975
DIABETES SEMINAR

SBH Sends Out License Renewal Forms

The Mississippi State Board of Health is mailing out a questionnaire with the new license renewal forms for all physicians, osteopaths and podiatrists to complete, according to Dr. Frank J. Morgan, Jr., Assistant State Health Officer.

"The Mississippi Legislature in its last session passed a bill providing for an annual renewal and reinstatement of physicians, osteopaths and podiatrists licenses," Dr. Morgan said. "This new law will permit us to take an annual survey of medical manpower in the state that we have not been able to do in the past."

"The survey will enable us to know what kind of specialists we have here in the state and which medical personnel are active or inactive," he said. "The survey is designed to fit with the national system of the National Council for Health Statistics."

"The results of the survey will provide valuable information to the state's medical associations, health planners and University of Mississippi Medical Center researchers.

According to Dr. Morgan, the renewal form and the questionnaire should be completed and returned to the Board of Health before June 30 with the renewal fee of $10. The license will be good from July 1, 1975, to June 30, 1976.

"I would like to emphasize that the personal information in this questionnaire will be confidential," Dr. Morgan said. "Only the final statistics as a whole will be released."

Family Medicine Opens Model Practice Clinics

With a projected goal of training 30 family physicians each year, the model practice clinics of the University of Mississippi Medical Center Department of Family Medicine will play a large role in producing medical manpower for Mississippi.

The second clinic, Candlestick Family Medical Center in south Jackson, opened in April. The first, McWillie Clinic, became part of the departmental program last year, serving patients in north Jackson.

The Jackson units are the Medical Center's first in a planned statewide system of community clinics, with the twofold purpose of giving family medicine residents experience in office practice patient care and distributing family doctors to small and large towns throughout the state.

Within the next few years, the UMC department expects to set up other clinics elsewhere in the state.

According to Dr. Wilfred Gillis, chairman of the family medicine department at the Medical Center, a new study shows that 85 per cent of the physicians



Dr. Charles D. Guess, left, south Jackson family physician, toured Candlestick Family Medical Center at the formal opening of the model practice clinic. Dr. Wilfred Gillis, chairman of the University Medical Center Department of Family Medicine, acted as tour guide. Candlestick is the second in a proposed system of community clinics throughout the state with the twin goals of giving family medicine residents a realistic training environment, and distributing family doctors throughout Mississippi.



Dr. Thomas J. Anderson, left, a family physician in Laurel and president of the Mississippi Academy of Family Physicians, was among guests of the University of Mississippi Medical Center when Candlestick Family Medical Center formally opened. Dr. Norman C. Nelson, center, UMC vice chancellor, chats with Dr. Anderson and Dr. Wilfred Gillis, chairman of the UMC Department of Family Medicine. The Mississippi family medicine program currently has 14 young physicians in residency training. Twelve more first-year residents will enter the program in July.

who train in community clinics as residents remain in the vicinity when they begin their own practice.

Physicians already practicing in the areas serve as part-time faculty for the clinics.

"Their participation in this program is invaluable because they know and understand the health needs of their community," Dr. Gillis said.

Patients at the clinics pay for all services which include, in addition to primary health care, counseling, family planning, and health education provided by the clinics' health care team and its consultants.

"Modern medical care is a team effort," Dr. Gillis said. "It takes more than a doctor and a nurse."

NHLI Recruits Patients for Study

The National Heart and Lung Institute announces the initiation of patient recruitment for a new National Cooperative Clinical Trial, the Aspirin Myocardial Infarction Study (AMIS).

It has been postulated that thrombosis plays a major role in both the early and late stages of coronary artery occlusion and that platelet aggregation is a large component in the formation of arterial thrombi. Aspirin, in small doses, inhibits platelet aggregation for prolonged periods of time, and therefore might be of value in preventing or retarding coronary occlusion in subjects with coronary heart disease. This would be reflected in a decrease in the incidence of myocardial infarction and a decrease in mortality.

To test this hypothesis, AMIS is seeking to enlist men and women, aged 30-69, who have sustained a documented myocardial infarction no less than 8 weeks or more than 60 months prior to entry into the study. These subjects will be randomly allocated into control and experimental groups with double-blind control of assigned medication over the follow-up period of three years.

The cooperation and support of the medical profession is essential for the success of the study. About 4,200 participants will be necessary to satisfy the statistical design of the study. Physicians can greatly assist in recruitment of these subjects by identifying those among their patients who qualify and referring them to a clinical center in their area.

The University of Mississippi Medical Center is one of the participating clinical centers; for information call (601) 362-4411, extension 2227. Inquiries about the study may also be made to the National Heart and Lung Institute. Contact: Dr. William Friedewald, Project Officer, AMIS Study, National Institutes of Health, Bethesda, Md. 20014, phone (301) 496-4323.

The question posed by this important clinical investigation has major public health implications. The knowledge to be gained from a successful study may benefit many millions of individuals.

Course in Critical Care Scheduled

Signs and symptoms are a patient's means of communicating with his physician and nurse. It is the responsibility of each member of the health care team to interpret these signs and translate them into action. Recognizing the importance of this interpretation, the American College of Chest Physicians and the Critical Care Program of the University of Tennessee will present the program, "Critical Care—A Postgraduate Course in Clinical Assessment for Nurses and Physicians," June 23-25, 1975, at the Hyatt Regency Hotel, Nashville.

Co-sponsors of this program are the American Association of Critical Care Nurses, Hospital Corporation of America, Middle Tennessee Heart Association, Society of Critical Care Medicine, Tennessee Lung Association and the Vanderbilt University School of Medicine, Department of Continuing Education.

This program will be devoted to an understanding

of the mechanisms and interrelationships of disease processes and their manifestations seen at the bedside. Each day is specifically subdivided and will consist of lecture, question and answer sessions and clinical conferences. Participants will attend all of the clinical conferences, which will feature a panel of experts who will discuss the latest advancements in the care of the critically ill patient.

A total of 17 hours credit may be earned under Category 1 of the American Medical Association's Physicians' Recognition Award. This program has also been approved for 1.6 CEU credits by the University of Tennessee.

Tuition fees for this course are: nurse—member co-sponsoring organization, $100; nurse—non-member co-sponsoring organization, $115; physician—member co-sponsoring organization, $115; and physician—non-member of co-sponsoring organization, $140; this fee includes ticket to Opryland, USA.

For further information, please contact: Bradford, W. Claxton, M.Ed., Associate Executive Director, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Ill. 60068.

DEATHS

BERMAN, MAXWELL DAVID, Jackson. Born Camilla, Ga., Nov. 5, 1906; M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1931; interned Grady Hospital, Atlanta, Ga., one year; surgery residency, same. 1932-33; died April 12, 1975, age 68.

COSTLEY, LINFIELD, Meadville. Born Meadville, Miss., Nov. 24, 1878; M.D., Memphis Hospital Medical College, Memphis, Tenn., 1901; Emeritus Member of MSMA and AMA; member of Fifty Year Club of MSMA; died April 22, 1975, age 97.

COX, JAMES W., Columbus. Born Columbus, Miss., Jan. 4, 1890; M.D., Chicago College of Medicine and Surgery, Chicago, Ill., 1912; interned Cook County Hospital, Chicago, Ill., one year; died April 24, 1975, age 85.

HOLLIS, DANIEL LESTER, Biloxi. Born Sulligent, Ala., Oct. 22, 1893; M.D., University of Alabama School of Medicine, Birmingham, Ala., 1915; interned Birmingham Infirmary one year; surgery residency, same, one year; Emeritus Member of MSMA and AMA; member of Fifty Year Club of MSMA; died April 19, 1975, age 81.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension
Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



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Scientific Assembly Begins Work for '76

The 1976 Annual Session is set for May 3-6, 1976, at Jackson's new downtown convention center Holiday Inn. The Council on Scientific Assembly has already begun planning for the 108th.

Acting by separate sections during the recent 107th Annual Session, the eight components of the Scientific Assembly named new chairmen, and two sections elected new secretaries. A new Section on Radiology was approved at the annual session by the House of Delegates.

Under the By-Laws, a section chairman serves a term of only one year, but section secretaries are elected for three years. Secretaries of the eight sections are elected on staggered terms.

Each office carrics an automatic seat and vote in the House of Delegates to assure proper representation of each scientific specialty.

Named to head the Section on Anesthesiology is Dr. James S. Cooper of Tupelo. Dr. Katherine Aldridge of Hattiesburg enters the second year of her three-year term as secretary.

Dr. Milam S. Cotten of Hattiesburg will chair the Section on EENT and Dr. James W. Rayner of Oxford enters the third year of his term as secretary.

Heading the Section on Family Practice is Dr. Ralph L. Brock of McComb. Dr. Hardy B. Woodbridge, Jr., of Jackson enters the second year of his three-year term as section secretary.

The internists chose Dr. Bernard Booth of Jackson as chairman of the Section on Medicine. Dr. Joe M. Ross, Jr., of Vicksburg enters his final year as secretary.

Dr. I. E. Gaddy of Gulfport heads the Section on Obstetrics and Gynecology. The new secretary is Dr. Wadie Abraham of Meridian.

Dr. James A. Sheffield of Gulfport is the new chairman of the Section on Pediatrics. Secretary Dr. Robert L. Abney, III, of Jackson enters his final year.

Dr. George J. Taylor of Morton will chair the Section on Preventive Medicine. Elected to a three-year term as secretary was Dr. W. E. Riecken, Jr., of Jackson.

New chairman for the Section on Surgery is Dr. Michael E. Jabaley of Jackson. Dr. Henry B. Tyler of Jackson enters the third year of his term as secretary.

Section chairman and secretary for the new Section on Radiology will be named during the radiologists' meeting this month.

Dr. James P. Spell of Jackson, association secretary-treasurer, is constitutional chairman of the Council on Scientific Assembly. He said, "The council will be meeting this summer to review preliminary plans for the 108th Annual Session and to begin actively working on the program."

He said that the exhibit prospectus for technical exhibitors will be released this fall. Specialty societies are invited to submit plans for concurrent meetings and requests for assignment of rooms, including those for meal occasions, he added.

The president, Dr. Jack A. Atkinson of Brookhaven, and the president-elect, Dr. Lyne S. Gamble of Greenville, are *ex officio* members of the council.

Board of Trustees Names 1975-76 Officers

Three new names appear on the roster of the association's governing body, the Board of Trustees. Elected for three year terms by the House of Delegates were Dr. Max L. Pharr, additional Trustee representing District 5; Dr. Sidney O. Graves of Natchez, representing District 8; and Dr. Paul H. Moore of Pascagoula, representing District 9.



Dr. Gilmore

Dr. Gerald P. Gable of Hattiesburg was re-elected to the District 7 post.

Dr. James O. Gilmore of Oxford, District 2, was re-elected Board chairman. Dr. Robert S. Caldwell of Tupelo, District 3, was named vice chairman and Dr. Gable remains Board secretary. The chairman, vice chairman and secretary make up the Executive Committee. Continuing to serve are Drs. Lyne S. Gamble of Greenville, District 1; Arthur A. Derrick, Jr., of Durant, District 4; Carl G. Evers of Jackson, District 5; and Joe S. Covington of Meridian, District 6. The president and immediate past president are voting members of the Board. Six general officers meet with the Board: president-elect, secretary-treasurer, speaker of the House of Delegates, vice speaker and AMA delegates.

Retiring from the Board were Drs. Everett Crawford of Tylertown and James T. Thompson of Moss Point.

Dr. Jack Atkinson Is Inaugurated President, Dr. Lyne S. Gamble Is Named President-elect

Dr. Lyne S. Gamble of Greenville was named president-elect of the association at the closing meeting of the 107th Annual Session, and Dr. Jack A. Atkinson of Brookhaven was inaugurated 1975-76 president, succeeding Dr. J. T. Davis of Corinth.

The four-day meet was headquartered at the Sheraton-Biloxi and featured meetings of the eight scientific sections, meetings of 17 specialty societies, and medical alumni and social occasions. More than 25 essayists presented a varied program which drew praise of registrants. Many of the scientific presentations will be published in future issues of the JOURNAL.

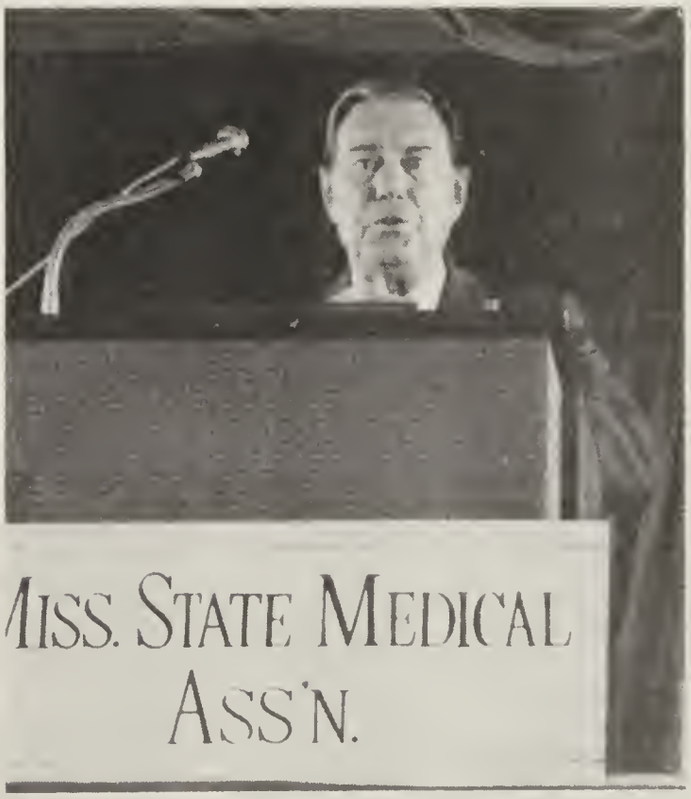
The Coast annual session had a registration of 794 which included 376 members, 53 M.D. guests, 15 interns, residents and students. Others included 17 guests (non M.D.), 124 exhibitors, 197 Auxiliary members, and 12 staff.

Handling a heavy business agenda, the House of Delegates acted on 16 reports, 6 of which were from the Board of Trustees, and 13 resolutions. Four reference committees conducted hearings before which members and guests appeared for discussion and debate.

Dr. J. T. Davis addressed the opening meeting of the House of Delegates on May 5 on the malpractice insurance crisis, continuing medical education, and the confidentiality of the physician/patient relationship. The 1974-75 president urged that physicians not forget that good records and good rapport with patients are still two basic ingredients for good medicine.



Three years of the association's presidency are represented by, from left, Dr. J. T. Davis of Corinth, immediate past president, 1974-75; Dr. Jack A. Atkinson of Brookhaven, newly inaugurated MSMA president, 1975-76; and Dr. Lyne S. Gamble of Greenville, the new president-elect, 1976-77.



Dr. Malcolm C. Todd of Long Beach, Calif., president of the American Medical Association, appeared as principal guest speaker of the annual session. He addressed the House of Delegates at the opening meeting.



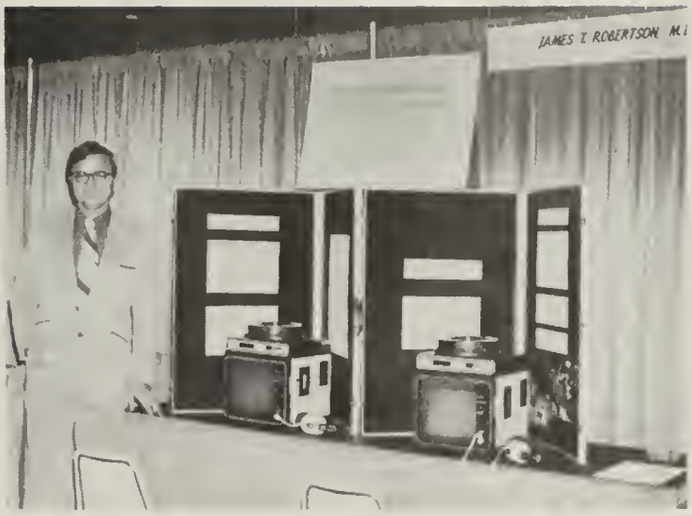
Past presidents of the association enjoy fraternal and traditional breakfast with special guests, Drs. Davis and Atkinson, candidates for select circle. Below, left Dr. Walter Simmons of Jackson, Speaker of the House of Delegates, greets members of the House. Center, Dr. C. D. Taylor, Jr., of Pass Christian, vice speaker, assists Dr. Simmons in presiding over the business of the House. Lower right, MSMA 1974-75 president, Dr. J. T. Davis of Corinth, presents "The President's Address" at the House of Delegates meeting on Monday.











Winners of the awards for best scientific exhibits are shown. Top left, "Abdominal and Obstetrical Ultrasonography" by Drs. Kenneth G. Carter and James M. Packer of Jackson received the first prize Aesculapius Award, an engraved walnut plaque, for best exhibit by a member(s) of the association. Top right, "The Transphenoidal Approach to Pituitary Tumors" by Dr. James T. Robertson of Memphis was presented the association's Scientific Achievement Award, a sculptured bronze medallion, in recognition of the best presentation by a nonmember. Lower left, "Pediatric Malignancies" by Drs. Richard C. Miller, Jeanette Pullen and Patricia C. Moynihan of the University Medical Center in Jackson received the second place award in the member category. Lower right, Dr. James P. Spell of Jackson, MSMA chairman of the Council on Scientific Assembly, presents the plaque to Dr. Miller.







Members of the Fifty Year Club of the association participated in their annual special luncheon meeting in conjunction with the annual session. Club "officers" are Board chairman Dr. James O. Gilmore and MSMA Membership Director Barbara Shelton, who serves as secretary. Two special awards were given during the Board of Trustees meeting on May 4. President J. T. Davis presented plaques commemorating the service of their late husbands to MSMA and the medical profession to center, Mrs. John B. Howell of Canton, and lower left, Mrs. Arthur Brown of Columbus.





Sharing the rostrum spotlight with Dr. Davis was Dr. Malcolm C. Todd of Long Beach, Calif., president of the American Medical Association, who discussed the malpractice insurance situation, the need for medicine to be united and the service obligations of the profession.

A gift of $12,211.35 was made to the University Medical Center by the state association and Woman's Auxiliary AMA-ERF campaign.

New vice presidents named to serve in 1975-76 are Drs. J. Edward Hill of Hollandale for the northern area, William B. Hopson, Jr., of Vicksburg, for the mid-state area, and J. P. Culpepper, III, of Hattiesburg, for the southern area.

Dr. Myron W. Lockey of Jackson was re-elected associate editor of the JOURNAL MSMA.

Dr. G. Swink Hicks of Natchez was re-elected as delegate to AMA and Dr. Stanley Hill of Corinth was re-elected to another term as alternate delegate to the AMA.

Delegates, tallied at 98 in the May 8 balloting, elected Dr. Max Pharr of Jackson as the additional trustee from District 5. Dr. Gerald P. Gable of Hattiesburg was re-elected to the Board and Dr. Sidney O. Graves of Natchez was elected to represent District 8 and Dr. Paul H. Moore of Pascagoula, District 9.

Elected to the Council on Budget and Finance were Drs. J. Dan Mitchell of Jackson and David L. Clippinger of Gulfport.

Dr. C. D. Taylor, Jr., of Pass Christian was named speaker of the House of Delegates and Dr. R. F. Triplett of Jackson is the new vice speaker.

Dr. Whitman B. Johnson of Clarksdale was elected to the Council on Medical Education. Named to the Council on Medical Service were Drs. Donald R. Ellis of Clarksdale, John R. Lovelace of Batesville, and Thomas N. Braddock of West Point.

Dr. Louis C. Lehmann of Natchez was elected





Top left, Dr. Thomas M. Davis of Jackson, center, was 1975 winner of the MSMA-Robins Award for ontstanding community service by a physician. President Davis and Mr. Willard Duvall of the A. H. Robins Company, at right, made the presentation of the engraved plaque to Dr. Davis, who was cited for his work as Hinds County coroner, in The Red Cross and Civilian Disaster Control in the Jackson area. Top right, Dr. Davis presented the yearly contribution made by physicians and their families to medical education, a check in the amount of $12,211.35, to medical school dean Dr. Norman Nelson, center, as Dr. Frank Bowen of Carthage, president of the Ole Miss Medical Alumni Association looks on. Lower left, Dr. Edgar T. Beddingfield of Wilson, N. C., at left, a member of the American Medical Political Action Committee Board, was present on May 8 to make a special award to the Mississippi PAC. Dr. L. Stacy Davison of Cleveland, MPAC chairman, accepted the award, an engraved plaque, for the "ratio of members to potential" category. Lower right, the Board of Trustees presented a special appreciation award to WAPT-TV in Jackson for their weekly public service series, "House Call." Dr. J. Dan Mitchell of Jackson, at right, association coordinator for the program, presented the award to Mr. Craig Potter of Jackson, WAPT moderator on "House Call."





a new member of the Council on Constitution and By-Laws and Drs. William B. Hunt of Grenada, Samuel B. Johnson of Jackson and Martin Flynt of Meridian were named to the Judicial Council.

Re-elected to the Council on Legislation was Dr. Everett Crawford of Tylertown. New members of the council are Drs. Charles R. Jenkins of Laurel and Ray H. Stewart of Gulfport.

The four-day annual meeting was approved for 12 prescribed hours of credit for continuation study requirements by the American Academy of Family Physicians and the American Medical Association's Physician Recognition Award.

Mrs. J. Edward Hill of Hollandale was inaugurated president of the Woman's Auxiliary to the MSMA in their concurrent annual meeting.

New officers elected by the ladies are Mesdames W. A. Brown of Mathiston, president-elect; Joe Herrington of Natchez, first vice president; G. S. Rowlett of Vicksburg, second vice president; Lee H.

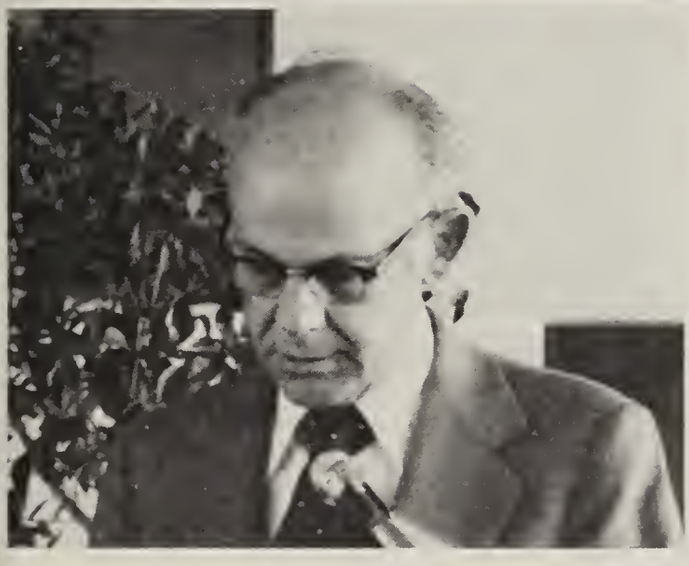


The Woman's Auxiliary to MSMA met during May 5-7 for the 51st annual session. New officers of the Auxiliary are, seated from left, Mrs. J. Edward Hill of Hollandale, president, and Mrs. W. A. Brown, Jr., of Mathiston, president-elect. Standing from left are, Mrs. Joe Herrington of Natchez, first vice president; Mrs. G. S. Rowlett of Vicksburg, second vice president; Mrs. Lee H. Rogers of Tupelo, third vice president; Mrs. Stanley Hartness of Koscinsko, fourth vice president; Mrs. William Spragins of Hollandale, corresponding secretary; Mrs. W. M. Hilbun of Meridian, recording secretary; and Mrs. A. T. Tatum of Petal, parliamentarian. Lower left, Dr. Jack A. Atkinson is administered the official oath of office by Board chairman James O. Gilmore. Executive Secretary Charles L. Mathews holds the official association Bible. Right, Dr. Davis is presented the James Grant Thompson Memorial Past President's Pin by Mrs. Thompson of Jackson.









Top, Members of the reference committees of the House of Delegates meet for breakfast and Dr. Simmons, Speaker, goes over duties and procedures of the committees. Chairmen of three of the reference committees are shown giving their reports before the House: at right, Dr. Richard Miller of Jackson, chairman of Medical Practices; lower right, Dr. Andrew K. Martinolich of Bay St. Louis, chairman of Reports of Officers and Board of Trustees; and left, Dr. Tom H. Mitchell of Vicksburg, chairman of the Council on Constitution and By-Laws.

Rogers of Tupelo, third vice president; Stanley Hartness of Kosciusko, fourth vice president; William Spragins of Hollandale, corresponding secretary; W. M. Hilbun of Meridian, recording secretary; and A. T. Tatum of Petal, parliamentarian.





Specialty Societies Hold Concurrent Meetings

A total of 17 specialty societies and related groups met concurrently with the association during the 107th Annual Session at the Sheraton-Biloxi. Scientific sessions and social occasions drew members of almost every specialty.

Pathologists from throughout the state attended the May 4 meeting of the Mississippi Association of Pathologists. Dr. Ben F. Martin of Columbus was named president-elect; Dr. Van B. Philpot, Jr., of Houston, president; and Dr. Julian C. Henderson of Jackson, secretary.

The Mississippi Dermatological Society met on May 3 and 4. Officers are president, Dr. Louis J. Wise of Jackson; president-elect, Dr. Ronald R.



New president of the Mississippi Association of Pathologists is Dr. Van B. Philpot of Houston, center. At left is Dr. W. Hollis Burrow of Greenville, outgoing president, and at right is Dr. Julian C. Henderson of Jackson, secretary. Not pictured is the president-elect, Dr. Ben Martin of Columbus.



New officers of the Flying Physicians Association, Inc., Mississippi Chapter, are Dr. Lee Rogers of Tupelo, at left, president, and Dr. John J. White of Jackson, secretary.



The Mississippi Orthopedic Society's new officers are: seated from left, Dr. James O. Manning of Jackson, outgoing president, and Dr. Sidney Berry of Jackson, president. Standing from left are Dr. Buford Yerger of Jackson, vice president; Dr. Cleve Johnson of Laurel, president-elect; and Dr. Hugh P. Brown of Jackson, secretary-treasurer.

Lubritz of Hattiesburg; secretary-treasurer, Dr. John A. Marascalco of Greenville; and member-at-large, Dr. W. Rodney Clement of Gulfport.

The Mississippi Society of Anesthesiologists held a dinner program on May 4 at the Sheraton. Officers are president, Dr. James M. Cooper of Tupelo, and secretary-treasurer, Dr. Katherine Aldridge of Hattiesburg.

Following the section meeting on May 7, the Mississippi Ob-Gyn Society conducted a luncheon meeting. New officers are president, Dr. Calvin Hull of Jackson; president-elect, Dr. Richard Hollis of Amory; vice president, Dr. Kenneth P. Pittman of Jackson; and secretary-treasurer, Dr. Lewis Lipscomb of Jackson.

Orthopedic surgeons convened on May 5 for a luncheon meeting. New officers are: president, Dr. Sidney R. Berry of Jackson; president-elect, Dr. Cleveland E. Johnson of Laurel; vice president, Dr. L. B. Yerger, Jr., of Jackson; and secretary-treasurer, Dr. Hugh P. Brown of Jackson.

The Mississippi chapter of the American College of Surgeons convened on May 6 for a scientific session, business meeting and luncheon. New officers are Dr. Richard H. Clark, Jr., of Hattiesburg, president; Dr. Thomas G. Barnes of Greenville, president-elect; and Dr. W. Briggs Hopson, Jr., of Vicksburg, secretary.

The Mississippi chapter of the Flying Physicians Association, Inc. held a cocktail party and dinner on May 6. Dr. Lee H. Rogers of Tupelo was elected president and Dr. John J. White of Jackson is secretary.

Family physicians met at a Mississippi Academy of Family Physicians luncheon on May 6. Dr. Thomas J. Anderson of Laurel is president. Other officers are Dr. Richard T. Furr of Ocean Springs, president-elect; Dr. Walter H. Rose of Indianola, vice president; and Dr. Marion L. Sigrest of Yazoo City, secretary-treasurer. New officers will be elected at the academy's July 9-12 annual meeting.

State urologists gathered at Biloxi on May 5 for a luncheon meeting. Dr. W. H. Merrell of Jackson assumed the presidency and Dr. William C. Gates of Columbus was elected to another term as secretary-treasurer.

A luncheon meeting on May 8 highlighted the annual gathering of the Mississippi Society of Internal Medicine. Dr. A. Robert Dill of Columbus is president and Dr. James C. Hays of Jackson is secretary.

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JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

JULY 1975

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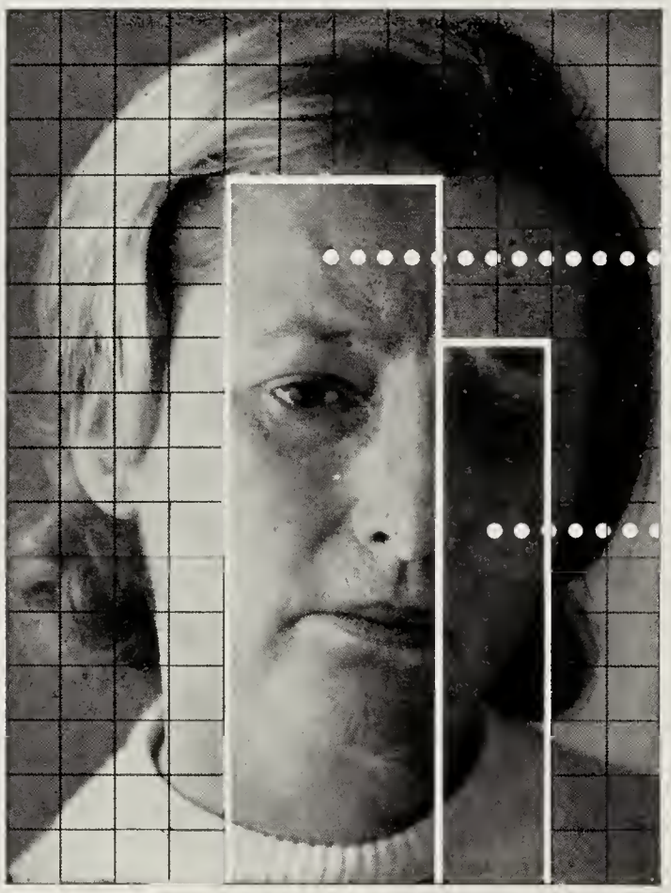
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
July 1975, Vol. XVI, No. 7

ORIGINAL PAPERS

Indications and Technique of Aortocoronary Bypass

MARTIN H. McMULLAN, M.D., and
THOMAS L. KILGORE, M.D.
Jackson, Mississippi

Aortocoronary bypass surgery has proven a safe, effective means of treating ischemic heart disease in selected patients, say the authors. They present their indications for this procedure and discuss their technique for the surgery.

THE INDICATIONS for aortocoronary bypass remain far from settled in that they are constantly changing as new data is gathered. Initially the primary indication was for the alleviation of chest pain in the angina syndrome. Since these early efforts, additional indications have arisen, and a few have been discarded. Almost certainly this will continue to be the case for the next few years. In our present state of knowledge, we have elected to divide the current indications for aortocoronary bypass into three categories. The first we have entitled "Absolute." These are the indications that seem to be most clear cut and embraced by the vast majority of cardiologists and cardiac surgeons. The second category is "Acceptable, But Debatable." These are indications in which there are often two schools of thought, and clear-cut guidelines are yet to be determined. The third category is "Contraindications." These represent entities which have fallen by the wayside as a viable indication for aortocoronary bypass.

Absolute. The overwhelming indication continues to fall into the area of angina pectoris. In the patient with angina two factors are most important. First is the anatomy. Generally we classify a lesion as critical and presumably flow-restricting when it narrows the lumen of a vessel by at least 70 per cent on angiography. If all three coronary arteries are involved with proximal critical stenoses and there are good distal vessels, we consider this patient with angina an ideal surgical candidate. Second is the character of the angina. Is it recent in onset? Is it stable? Does it last for prolonged periods of time? Is it occurring with less exertion or occurring at rest? Has it become nocturnal? These factors not only sway us toward operative intervention, but dictate an early approach with surgery usually being recommended during the same hospitalization.

A second generally acceptable indication for aortocoronary bypass is in the patient who undergoes catheterization for symptomatic ischemic heart disease and is found to have a critical stenosis of the left main coronary artery. We have treated this as a surgical emergency almost always offering surgery the same day as catheterization because of the potential lethal hazard of this lesion.

Presented at 1st Annual Symposium on Heart Disease, Sept. 13-14, 1974, Mississippi Baptist Hospital, Jackson, Miss.

Life-threatening arrhythmia such as ventricular tachycardia and ventricular fibrillation in the presence of angiographically demonstrated ischemic heart disease serves as a dramatic indication for aortocoronary bypass. This is an uncommon indication and is most frequently associated with a ventricular aneurysm, though certainly not always. Physiologically it would appear that a markedly ischemic focus serves as a trigger zone of irritability for surrounding ischemic muscle, initiating runs of ventricular tachycardia and even ventricular fibrillation.

One final indication for aortocoronary bypass which we feel is quite acceptable is in the patient with valvular or congenital heart disease who, at catheterization, undergoes coronary angiography as well and is found to have critical stenosis of one or more coronary arteries. Frequently in aortic or mitral valvular disease and even in congenital lesions patients may have chest pain with normal coronary anatomy. Therefore, it is virtually impossible to state that a particular stenotic lesion of a coronary artery is responsible for a patient's symptom of chest pain. However, our reasoning has been that since mortality and complication rates have been low, we advocate aortocoronary bypass to critically stenotic vessels at the time of performing valve replacement or repair of a congenital defect. This is an effort to prevent intraoperative and postoperative myocardial ischemia because of the stenotic coronary lesions and because of the necessity for cross-clamping the aorta during the valve replacement or congenital repair. We feel a more satisfactory long-term result is assured. An additional, less important reason is that to perform aortocoronary bypass at some later date when symptoms of angina become prevalent makes for a much more technically difficult procedure because of the formation of adhesions.

Acceptable but Debatable. Exercise treadmill testing with simultaneous electrocardiographic monitoring is becoming more and more popular as a screening test for ischemic heart disease. Not infrequently, a patient is exercised because of an abnormal resting electrocardiogram, atypical chest pain, a family history of ischemic heart disease, or even as part of an annual physical examination. If the exercise test is positive, the patient is usually advised to undergo coronary angiography. We, the surgeons, may then be faced with the decision of recommending surgery to an essentially asymptomatic patient. Our policy in recent months in a patient with a definitely positive exercise test and critical stenosis of at least the proximal left anterior descending coronary artery, even if essentially asymptomatic, has been to advise aortocoronary bypass. The converse is true as well. In a symptomatic patient with questionably critical stenosis of at least the left anterior descending, we have used the treadmill in an effort to determine if a particular lesion is, in fact, flow-restricting. That is, if the exercise test is positive with this questionably critical lesion, we have generally advised surgery. If, on the other hand, the exercise test is negative, we have advised a conservative regimen with serial exercise testing. In the event the stress test becomes positive at some future date, we would then favor a surgical approach if no contraindications to surgery have developed in the interim.

In a young patient, arbitrarily defined as less than 45 years of age, who has a documented acute myocardial infarction, it appears reasonable to catheterize this patient in an effort to determine his coronary anatomy. We then have the basis for a great deal of information as to his prognosis and a guide to his activity level. If he has occluded a single-vessel with little ventricular impairment and the remaining major coronary arteries are free of disease he presumably can return to full-time, unrestricted activity. If, on the other hand, he has three-vessel disease, statistically his mortality is about 10 per cent per year.[1] At this point we, as surgeons, become involved in very difficult decisions. There is no hard data as yet which indicates we are prolonging life with aortocoronary bypass, although there may be indirect evidence.[2] Therefore, it is somewhat difficult to offer a surgical procedure to an otherwise asymptomatic young man, even though he has what appears to be angiographically critical stenosis of at least one coronary artery with another occluded from his previous infarction. Again, we have turned to the treadmill for help. If there is a positive treadmill exercise study, we would offer this patient surgery with no hesitation. We have, on rare occasion, operated on essentially asymptomatic patients with three-vessel coronary artery disease without performing a treadmill test primarily because of the extreme critical appearance of the lesions on angiography.

As mentioned previously, the prognosis in triple-vessel disease as opposed to single-vessel disease is quite different. The natural history of three-vessel disease with its $>$ 10 per cent per year mortality serves as much less of a problem in decisions regard-

ing aortocoronary bypass. When one considers that the projected mortality as reported in the series by Moberg[3] is 2 per cent per year for isolated right or circumflex coronary lesions and 4 per cent per year for left anterior descending lesions, this makes for a more difficult decision. In the past we have performed aortocoronary bypass on an occasional patient with isolated right or circumflex coronary artery disease. Usually this has been in a patient with a severely critical stenosis of a dominant vessel which seemingly supplies a large mass of myocardium and in whom angina is a disabling symptom. It is safe to say that our trend is now away from this approach especially as applied to the circumflex coronary artery. On the other hand, we have continued to bypass isolated critical lesions of the left anterior descending for two reasons. First, the natural history of this lesion indicates twice the mortality rate per year when compared to isolated right or circumflex lesions. Secondly, the left anterior descending supplies the septum and anterolateral wall of the ventricle. Occlusions of this vessel result in varying degrees of decreased ventricular function in a high percentage of cases thereby contributing significantly to a diminished quality of life.

Contraindications. Not infrequently a patient who has atherosclerotic critical stenosis segmentally throughout the entire course of one or more coronary arteries is encountered. Experience has taught us to avoid a surgical approach to these vessels. The chance of obtaining a good flow through a graft inserted into a diffusely diseased vessel is quite poor and the chance of producing myocardial damage in attempting an anastomosis to a brittle, calcified vessel is great. The one possible exception to this is the diffusely diseased right coronary artery. For unexplained reasons, the right coronary artery lends itself, technically, to endarterectomy, whereas the left anterior descending and circumflex do not. However, the unpredictability of the results with endarterectomy has caused us to all but abandon it as a procedure, even in the right coronary artery except in those instances where we are technically forced into it.

Another absolute contraindication to aortocoronary bypass is the patient with markedly impaired ventricular function, usually due to previous infarction with scar formation, but also due to associated cardiomyopathy. A number of series have reported extremely poor results, both in terms of increased operative mortality and poor long-term results. This, too, has been our experience. In the past we have had an occasional patient we could not bring off cardiopulmonary bypass. Most of these have had markedly reduced systolic ejection fraction prior to surgery. Preliminary investigation of our late results indicates that reduced ventricular function is a significant risk factor in both early and late mortality. This parallels the data published by Collins, et al.[4]

Finally, congestive heart failure as a presenting or dominant symptom with an elevated left ventricular end diastolic pressure and markedly reduced systolic ejection fraction has been considered a contraindication to surgery in our hands. Both the New York University[5] and Alabama groups[6] have published data confirming the higher operative mortality and poor late results in these patients.

TECHNIQUE

In general, the entire procedure of aortocoronary bypass may require from an hour and a half to two and a half hours. The time spent on the cardiopulmonary bypass machine, of course, is directly related to what is required at the time of surgery. A single bypass may require only 20 minutes or so, whereas a triple bypass may require an hour on cardiopulmonary bypass.

The initial effort is in the cannulation to establish cardiopulmonary bypass. A tube is inserted into the right atrium for the purpose of delivering unoxygenated blood to the cardiopulmonary bypass machine where it is oxygenated and then returned by way of a cannula inserted into the ascending aorta perfusing the remainder of the body. The patient is cooled to 30°-32°C and the heart fibrillated. The right coronary artery is isolated between two heavy ligatures without cross clamping the aorta. The reversed saphenous vein graft segment is then sutured in an end-to-side fashion with a running suture of 6-0 Prolene, a monofilament extremely fine suture that has very little tissue resistance. The proximal end of the anastomosis is made utilizing an aortic side clamp and excising a button of aorta in an effort to obtain as wide an anastomosis as technically possible. The graft is sutured in an end-to-side fashion with a Prolene suture. The left anterior descending and circumflex coronary arteries are bypassed in a similar fashion except the aorta is cross clamped during the distal anastomosis. After rewarming, cardiopulmonary bypass is discontinued and decannulation effected. Flows are measured with an electromagnetic flowmeter. A high degree of correlation exists between flow and patency rate, both early and late. A flow rate of greater than 40 cc in any graft

has an 85 per cent to 90 per cent early patency rate.[7] Anything less than 20 cc per minute has a very dismal patency rate.

SUMMARY

Aortocoronary bypass surgery has proven a safe, effective means of treating ischemic heart disease in selected patients. Our indications for this procedure have been presented. As new data is accumulated it is possible these indications may require modification.

★★★

1600 North State Street (39202)

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BICENTENNIAL NOTE

Of the 56 courageous men who signed the Declaration of Independence, four were physicians. They were Lyman Hall (Georgia), Benjamin Rush (Pennsylvania), Josiah Bartlett (New Hampshire), and Matthew Thornton (New Hampshire).

The American Medical Association has had written a play entitled "Dr. Rush Pays a House Call" to honor these Founding Fathers. For more information about the play, contact:

Alfred Stern
408 West 57th Street
New York, N. Y. 10019

Results of Surgery for Coronary Artery Disease

THOMAS L. KILGORE, JR., M.D., MARTIN H. McMULLAN, M.D.,
H. DAVIS DEAR, M.D., and McKAMY SMITH, M.D.
Jackson, Mississippi

A two-year follow-up study of 218 patients having undergone coronary bypass surgery for ischemic heart disease is presented. The authors feel it indicates that not only is the functional status of the majority of patients improved regarding relief of angina pectoris and rehabilitation, but also demonstrates an improvement in the annual attrition rate from the disease in the surgical patient (1 per cent) when compared to that of the unoperated patient (6.5 per cent).

STANDING AT THE TOP of the list of serious health disorders in this country, coronary heart disease continues to challenge the medical profession. Many different forms of medical and surgical therapy have been employed in the past in attempts to control the disease. Some medical measures, including the use of antiarrhythmic agents and the use of coronary care systems, have improved the salvage rate among patients with acute myocardial infarction. However, the long-term follow-up of medically treated patients has shown a continued impressive annual mortality rate. The early surgical procedures such as sympathectomy, pericardiectomy, internal mammary artery ligation, etc. had no sound physiological basis and have been discarded as useless. The failure of medical regimens to control the disease on a long-term basis has been the stimulus for the development of a sound surgical approach to the problem. The aortocoronary saphenous vein graft operation, based on improving coronary blood flow by bypassing proximal stenotic areas in the coronary tree, has been successful in eliminating or improving the anginal syndrome in a majority of patients. However, questions have been raised regarding the efficacy of the operation in prolonging life. The problem in evaluating this surgical approach has been the lack of adequate studies comparing surgical with medical results in randomized patients with similar stages of disease. The purpose of this paper is to present the follow-up results of patients treated surgically at the Mississippi Baptist Hospital. These results will be compared with the results of the natural history study published by Reeves, et al.[1] While such a comparative study is not precise, trends should be evident.

Cardiac surgical procedures were initiated in the Mississippi Baptist Hospital during the latter part of 1971. The clinical material available from January 1972 through June 1973 will comprise our study group of 218 coronary bypass cases so as to give a mean follow-up of 24.5 months with a range of 15 to 32 months (see Table 1). A total of 500 grafts were implanted for an average of 2.3 grafts per patient. Of the 218 surgical cases, only 30 had single bypass grafts, the remainder having two or more grafts. For the purpose of this study the patients will be considered as having one, two or three vessel disease based on the number of grafts implanted.

Table 2 compares the annual mortality of our postoperative patients with the annual mortality of medically treated patients as published by Reeves, et al.[1] In the category of patients with one vessel disease, there were no operative or late deaths. There were two operative deaths (2 per cent) in the surgical patients with two vessel disease, but no late deaths. There were no operative deaths in our patients with three and four grafts, but there were two late deaths at two years from myocardial infarction in this category. Both of these cases were noted to have severe distal disease at the time of surgery and both had less than average blood flow through all grafts.

Presented at 1st Annual Symposium on Heart Disease, Sept. 13-14, 1974, Mississippi Baptist Hospital, Jackson, Miss.

The difference in the annual attrition rate between the non-operative and the operative groups is impressive—6.8 per cent per year in the unoperated two vessel disease as opposed to 1 per cent of the two vessel surgical group; 11.4 per cent per year in the unoperated three vessel group as opposed to 1 per cent annual mortality in our three and four vessel surgical category. The combined natural history study had an average attrition rate of 6.5 per cent considering all categories. By comparison the annual attrition rate in the total surgical group was 0.9 per cent, operative mortality included.

TABLE 1

SURGICAL CASES JAN. 1, 1972-JULY 1973

All cases		225
Reclassified		5
Cancer	2	
Valve disease	1	
Suicide	1	
Cardiomyopathy	1	
Lost to follow-up		2
Range of follow-up (months)		15-32
Mean follow-up (months)		24.5
Total grafts (2.3 per pt.)		500

Table 3 summarizes the subjective results at the end of the follow-up period (mean 24.5 months) in our surgical patients. After surgery 82 per cent had no angina and another 15 per cent had less angina with only 3 per cent having had no change or increasing angina.

TABLE 3

SURGICAL RELIEF OF ANGINA PECTORIS

	Per Cent
No angina	82
Less angina	15
No change	2
More angina	1
	100

Table 4 summarizes the functional status of the surgical patients at the end of the follow-up period. Prior to hospitalization 28 per cent were unrestricted and 72 per cent were restricted regarding their physical activity. Following surgery, 85 percent were unrestricted at two years while 15 per cent remained with some restrictions and half of these were able to work.

DISCUSSION

To justify the surgical approach to coronary artery disease, the risk, discomfort, and expense of the operation should be shown to be more than compensated for in clinical improvement and extension of life when compared with similar patients treated medically. The surgical mortality in patients with stable angina pectoris appears to be less than 6 per cent[2-6] and the operative mortality of 1 per cent in this series compares favorably with these reports. The clinical improvement of the majority of patients treated surgically would appear to more than offset the early postoperative discomfort suffered by the patient. From the economic standpoint, the expense

TABLE 2

COMPARISON OF ANNUAL MORTALITY IN NATURAL HISTORY STUDIES* AND PATIENTS HAVING UNDERGONE AORTOCORONARY BYPASS SURGERY

Combined Natural History Studies							
VESSELS INVOLVED	CASES	ANNUAL PER CENT MORTALITY	*Cases*	*Operative Mortality*	*Late Mortality*	*Combined Operative and Late Mortality*	*Per Cent Annual Attrition*
1	265	2.2 ± 0.4	30	0	0	0	0
2	220	6.8 ± 0.7	99	2 (2%)†	0	2 (2%)	1
3	220	11.4 ± 0.9	89	0	2 (2.2%)	2 (2.2%)	1
Total	705	6.5 ± 0.6	218	2 (0.9%)	2 (0.9%)	4 (1.8%)	0.9

* Data from Reeves, et al.[1]

† 1 operative "pump failure" death; 1 postoperative death from myocardial infarction.

of the operation would seem to be justified by the fact that only 57 per cent of our patients were working prior to surgery whereas 79 per cent were gainfully employed at the late follow-up examination.

TABLE 4

FUNCTIONAL STATUS OF SURGICAL PATIENTS

	Preoperative PER CENT	*Postoperative* PER CENT
Unrestricted		
Working	26	71
Retired	2	14
Restricted		
Working	31	8
Retired	41	7
	100	100

The annual attrition rate of 1 per cent in our surgical patients is impressive when compared to the annual mortality of 6.5 per cent in the unoperated patients. However, this comparison of survival rates of patients treated medically and surgically may be misleading to a degree. The results in patients who received medical treatment were obtained during a period when some forms of current medical therapy were not available. Additionally, it is not possible to state how many patients receiving only medical therapy would have been suitable candidates for surgery. Since patients with diffuse coronary disease and poor left ventricular function are usually not selected for surgery, the medical group may have included a significant number of patients with more advanced disease. In spite of these reservations, our data does suggest that the annual attrition rate of coronary heart disease can be favorably altered by coronary bypass surgery.

SUMMARY

Between January 1972 and July 1973, 218 consecutive patients underwent coronary bypass surgery and have been followed for a mean period of 24.5 months. The operative mortality was 0.9 per cent and late mortality was also 0.9 per cent. The annual attrition rate of 0.9 per cent (compared to the expected attrition rate of 6.5 per cent) gives further support toward the surgical approach in patients with coronary heart disease. The majority of surgical patients (82 per cent) were free of angina at the end of the follow-up period. Seventy-nine per cent of the patients in this series were gainfully employed at the last follow-up examination whereas only 57 per cent were employed prior to surgery. This data suggests that the surgical risk, discomfort and expense of coronary bypass surgery are justified by clinical improvement, rehabilitation, and extension of life when compared to the medically treated patient. ★★★

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Radiologic Seminar CLIII: The Lateral Decubitus Radiograph: An Aid to the Diagnosis of Endobronchial Foreign Bodies

BERNARD BLUMENTHAL, M.D.
Jackson, Mississippi

THE DIAGNOSIS of an aspirated foreign body is a perplexing pediatric problem. A history of acute onset of choking, gagging, or coughing is strongly suggestive of acute foreign body aspiration. However, after the initial post-aspiration period, there is often a symptom-free interval which may last hours, days, or even months. If the child is seen during this asymptomatic period the diagnosis may be missed. Chest radiography is the best available diagnostic modality for the solution of this problem. If the foreign body is radiopaque the radiographic diagnosis is simple. However, the most common aspirated foreign bodies (peanuts, popcorn, etc.) are not radiopaque and therefore may present a difficult diagnostic problem.

Sponsored by Mississippi Radiological Society.
From the Department of Radiology, University Hospital, Jackson, Miss.

A foreign body in the tracheobronchial tree may cause either atelectasis or obstruction. Obstructive emphysema occurs as the result of the "ball-valve" effect of an obstructing object. Air may enter the lung around a partially obstructing foreign body because of normal bronchial dilatation during inspiration. During expiration, however, the bronchial lumen narrows trapping air in the lungs distal to the obstruction.[1] This localized air-trapping distal to a bronchial foreign body is best seen on expiratory radiographs of the chest since air-trapping may be masked during inspiration when both lungs are fully distended with air. Because infants and young children are unable to cooperate, it is difficult to obtain satisfactory radiographs of the chest during the desired phase of respiration. This problem can be resolved by examination of the chest under image-intensified fluoroscopy. At fluoroscopy the obstructed



Figure 1A

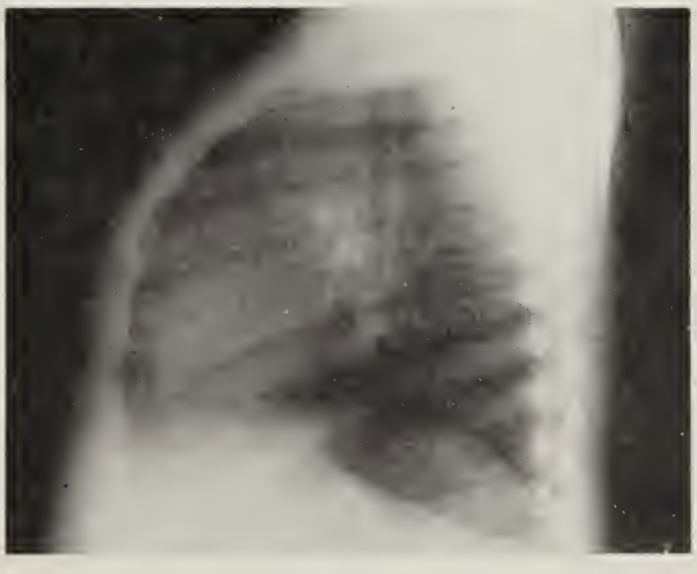


Figure 1B

Figure 1. Two-year-old girl with a peanut in the bronchus intermedius. There is hyperlucency of the right middle and right lower lobes (A) and depression of the right hemidiaphragm (B).



Figure 2A



Figure 2B

Figure 2. A. Right lateral decubitus radiograph demonstrating definite hyperlucency of the right middle and right lower lobes indicating localized air-trapping. B. Left lateral decubitus radiograph demonstrating normal "expiratory" emptying of the left lung.

lung segment would remain hyperlucent on expiration. If a lobar or main bronchus is involved there would be a contra-lateral shift of the mediastinum during expiration. Fluoroscopic observation should be recorded on appropriate spot films or preferably on video tape.

A simpler and more convenient method to determine the presence of air-trapping is the use of lateral decubitus radiographs.[2] When the child is placed on his side the dependent hemithorax is splinted, resulting in restriction of motion of the thoracic cage on that side. With restriction of the hemithorax, the lung on the dependent side tends to be under-aerated, the intercostal spaces narrowed, and the hemidiaphragm elevated. Conversely, the opposite, uppermost, hemithorax is not restricted and the lung is well aerated. If air-trapping is present the involved lung, lobe, or segment will remain expanded even when that side of the thorax is in the dependent position and will appear hyperlucent.

The lateral decubitus examination of the chest requires no complex equipment, or cooperation on the part of the child. As with all pediatric radiography, meticulous attention must be paid to technique. The exposure time must be kept as short as possible. The child's position must be carefully adjusted. It is advantageous to place the child directly on a hard surface rather than a cushion. While radiographs need not be exposed during any particular phase of respiration, expiratory films are easier to evaluate.

The use of lateral decubitus radiographs of the chest has therefore proven to be a simple and rapid means of diagnosis and localization of non-radiopaque endobronchial foreign bodies. The method can be used in any hospital or office that has basic radiographic equipment. ★★★

2500 North State Street (39216)

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Address of the President

J. T. DAVIS, M.D.
Corinth, Mississippi

TWELVE SHORT MONTHS ago in this room I assumed the duties and responsibilities of the presidency of the Mississippi State Medical Association, the highest honor the association can bestow upon any one of its members. It was a great milestone in my life and the pinnacle of my 12 years of service as an officer at the state level.

Serving as your president has been rewarding. It has been an eventful year and one filled with enriching experiences as I traveled throughout the state visiting with component medical societies, the Woman's Auxiliary, medical students, government leaders, and insurance officials on behalf of your association. During this short period I have learned a great deal about our organization and as we observe the 109th anniversary of the Mississippi State Medical Association at this 107th Annual Session, I am happy to report that the health of your association is excellent.

The membership of the Mississippi State Medical Association is at an all time high, the roster of Mississippi Political Action Committee members has doubled in less than 12 months, and the Mississippi Foundation for Medical Care continues to grow in size, strength, and stature. I strongly urge your continued support of the foundation as an essential mechanism to support and identify the delivery of quality medical care. Absenteeism is rare at our Board of Trustees and other committee meetings at the state level. Your executive secretary has surrounded himself with a most competent, industrious, and loyal staff who in the past two years has performed well under the greatest administrative load in the history of our association. The expanding and increasing activities and services of organized medicine in Mississippi have been so great that a demand for additional working space has been created. At this time this demand is being met by leasing additional office space. It is my strong recommendation that in the not too distant future we consider a new building program based on anticipated growth of present programs.

I personally believe that all this is a good omen. It points up the growing concern of our members with the need of organized medicine to deal with the issues of the day and in this concern there is strength. It is new and exciting to find that as many young physicians become increasingly interested in the socioeconomics of health care and in their prospects for professional freedom, they are turning to an acceptance of and an enthusiasm for organized medicine. There is a growing recognition of the fact that our profession must act in concert and that the concerns of oncoming generations can become the future association policies if work is done to make them so. The life blood of any organization must be the enthusiasm of youth tempered with experience.

Organization and the process of leadership must proceed on a step by step basis beginning at the local level and moving in an orderly fashion to the state and national levels. The younger men selected to high office should be knowledgeable and experienced physicians seasoned by civic and professional service at the county, component society, and state committee levels. To do this one must first become a member—then a member dedicated and willing to work for his profession with an open mind. Proper indoctrination and orientation of new members by this association may be one of the most needed factors in our organization today. The profession that sponsors and executes an orderly process for training the young physician for leadership may be assured of survival in the changing world of tomorrow.

Today the practice of medicine and the profession of medicine are beset by many issues. These issues generally concern three subjects. They are the cost of medical care, the quality of medical care, and access to medical care. There must be solutions to these issues. They will be forthcoming with or with-

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President, Mississippi State Medical Association, 1974-75. Read before the House of Delegates, 107th Annual Session, Biloxi, May 5, 1975.

out our assistance. If we are to maintain our professional freedom, one of our major responsibilities must be to do all in our power to make the system of private practice of medicine work. This requires more than just rhetoric. We must continually mold a system that delivers quality medical care at a reasonable cost to all Americans. We must do this through our local, state, and national organizational endeavors. To reinforce our position and strengthen our voice in this regard, I suggest very strongly that we establish closer liaison with our allies in the health care field and also better inform the public of our goals.

Specifically within this context, there are concerns I would like to address at this annual session based on my discussions with you and others as your president this year. I should note at the beginning that these concerns are interrelated and our response to them will have a far reaching effect on the future of the practice of medicine. They are professional liability insurance, continuing medical education, and the confidentiality of the physician/patient relationship.

PROFESSIONAL LIABILITY

In this day of cynicism and the so-called "legal rights explosion," professional liability has become a nightmare to the medical profession, a field of diminishing return and decreasing interest to the insurance industry, a "happy hunting ground" for a few members of the legal profession, and a cause of increased health care costs for the public—our patients.

The problem has gained such momentum that the dilemma is now this: insurance companies are raising premiums to cover rising dollars in claims most of which are going for administration and legal fees, and the physician is practicing defensive medicine and raising his fees to cover increased premiums. We must express our concern about this to our patients. they are the victims of the dilemma. They should be our strongest allies.

For many years physicians in Mississippi have enjoyed a relatively stable professional liability insurance market. The St. Paul Insurance Program, endorsed by the Mississippi State Medical Association since 1961, has served the association and public well. Our premiums have been among the lowest in the nation. Recently, however, the "physicians' liability insurance crisis" has begun to bubble over into our state. Due to a national policy adopted by the St. Paul Insurance Company, this year the company will discontinue insurance coverage on an "occurrence" basis and convert to a claims-made policy. This means that a physician will be insured only for claims reported during the years that he continues to pay his insurance premium with the option of purchasing coverage for unreported claims when he retires or otherwise drops his St. Paul coverage.

Obviously there are no easy solutions to the malpractice problem but the present system is not working and some new approaches are clearly indicated. A system of arbitration and other changes in the present legal system for handling malpractice claims have been suggested. There is no doubt that new initiates and innovations will have to be forthcoming because the situation has become acute.

A strong Mississippi State Medical Association professional liability insurance committee has recently been appointed and is now exploring every potential solution to this crisis. This committee will have recommendations for your consideration and support. Solutions to this problem will require our best efforts and I would remind you that if we fail, the federal government will be called on to fill the void. In our efforts to solve this problem, let us not forget that good records and good rapport with out patients are still two basic ingredients for good medicine.

CONTINUING MEDICAL EDUCATION

Now let us turn our attention to the rapidly expanding program of continuing medical education of which you have heard so much during the past two years. The need for this program has long been recognized. In 1952 the Council on Medical Education of the American Medical Association initiated a study of postgraduate education. In 1975 the AMA House of Delegates approved a document "Objectives and Basic Principles of Postgraduate Medical Education" to assist institutions in their continuing medical education. Since that time the program has reached major proportions.

The rapid advances in scientific medicine during the past two decades have produced an overwhelming mass of data and medical knowledge. Such that for the busy private practitioner to keep abreast is almost beyond human endeavor. He must have some help and this help is available through the numerous well organized postgraduate courses from which he may choose.

Also, during the past decade, the entry of the third party into the health care field and the intrusion of the federal government into the private prac-

tice of medicine have further usurped the physician's time and left him groping in a quagmire of legislative regulations, red tape, and paper work.

Never before has the physician's time been more valuable requiring strict budgeting to allow time for his patient's care. The demand today that he deliver quality medical care, document that care with complete records in the hospital, participate in organized medicine, be active in civic affairs of his community as well as fight for his life in the political arena, leaves him little time for continuing medical education, family life, or recreation.

However, to survive, continuing medical education must be wedged into that already overcrowded time budget. The concept of the PSRO Program sponsored by the Mississippi Foundation for Medical Care in the state of Mississippi is basically one of continuing education and we must make sure that in fact education is its most important product. Also, the process of continuing medical education is without a doubt one of the keys to the physician's professional liability crisis.

Medicine is a lifetime of learning. The dedicated physician interested in quality care for his patients has for many years availed himself of at least a part of the voluminous supply of scientific knowledge offered in various well organized postgraduate courses. Only now all members of the profession must face the fact that credibility for the delivery of quality care can best be documented by earnest efforts toward continuing medical education.

The Mississippi State Medical Association is an approved accrediting agency for continuing medical education and I strongly recommend that we redouble our efforts in this essential program both at the component and state society level. We should all note with pride that the scientific program at this 107th Annual Session has been accredited for continuing medical education hours prescribed for the AMA's Physicians' Recognition Award and membership in the American Academy of Family Physicians.

CONFIDENTIALITY

Hundreds of years ago a wise man wrote one of the basic tenets of our profession as follows:

> "Whatever in connection with my professional practice, or not in connection with it, I may see or hear which ought not to be spoken abroad I will not divulge as reckoning that all should be kept secret."[1]

[1] From Oath of Hippocrates.

This statement of confidentiality has been reinforced by custom and law over the years. Today, however, it is under attack. The individual's right-to-privacy is at stake. During recent years confidentiality between patient and physician has been severely trampled by third party intrusions. The issue strikes at the very heart of successful implementation of the PSRO Program in the respective states. It may well prove a potent aggravating factor in the medical liability crisis that is severely threatening the cost and availability of quality medical care.

After four years of study we have recently been furnished our first comprehensive picture of the vast record keeping system which our government maintains. I believe it is reflective of the problem. The government's system contains personal data on millions of Americans. We are just talking about the government here—at this time no one has any idea of what private enterprise has accumulated.

Federal agencies have some 858 data banks or record systems and these contain at least one and a quarter billion records on individual Americans.

Describing this vast array of records, former Senator Sam J. Erwin, who headed a senate committee which probed into the matter, related:

> "These data banks vary a great deal in size and type. They contain all sorts of data from civil service personnel records to an inventory of electrical power users' household appliances computerized by the Tennessee Valley Authority. Information about 200,000 gun owners and two million coin collectors is kept on treasury department computers. An army general has computerized his protocol lists. The air force reports a data bank containing the religious affiliation of all air force military personnel."

Applying the data collection problem to medicine, let us note a few things. More and more patients are having their medical bills paid by third parties. These parties want information for payment purposes. Further, there is this growing matter of accountability of the quality and necessity of services provided to patients. I believe we have a particular obligation to our patients to be sure that they are fully cognizant of what medical information they approve for release. This is not always an easy task. Here again, however, the public, our patients, can be our most important ally in protecting the confidentiality of the physician/patient relationship.

Our own efforts in this regard in developing the Professional Standards Review Organization Pro-

gram (PSRO) for our state have been to do everything possible to protect the confidentiality of medical information. Without this protection the review system will expose the physician to unwarranted litigation and the system will eventually become meaningless. I am happy to report to you that with the support of the Mississippi Hospital Association, a bill was enacted during the recent legislative session that gives a legal shelter to PSRO information in Mississippi hospitals. We must work to expand this shelter further.

In closing I would like to briefly touch on several other matters of importance to the profession.

Our American Medical Association has revised and reintroduced a national health insurance bill in the 94th Congress. It will be most important for medicine to get behind this bill. The AMA and our state medical association will be sending you information about the bill. Let's get the same 100 per cent support for it from our congressional delegation that we got for Medicredit.

Last year in its closing hours, the congress passed what is called the National Health Planning and Resources Development Act of 1974. This act was described by opponents and proponents as the most important health legislation to pass congress since Medicare. Our "friend" Senator Kennedy said it was a necessary prelude to national health insurance. This act is described in a report from our Council on Medical Service. I urge you to become familiar with the act and to make your colleagues back home familiar with it.

This year we will have a state election. Through the health voting index on each member of the 1972-76 Mississippi Legislature and with our increased MPAC membership, you have laid the groundwork for an active and constructive participation by our profession in this year's election. I urge you to immediately begin to "get active" when you return home. Our MPAC will be furnishing you further information in this regard.

In conclusion at this 107th Annual Session, we can look back and say we have come a long and successful way. The future offers many opportunities and challenges that will test our willingness to give of ourselves as our predecessors have done before us. In the words of Abraham Lincoln ". . . you cannot escape the responsibilities of tomorrow by avoiding them today. . . ." Let us be proud of our profession. There is no higher education than the study of medicine and no profession offers greater rewards of human satisfaction in helping others. ★★★

815 Childs Street (38834)

FINANCIAL WIZARD: One who can support the government, a family, and a car on one income.

—*N. Miss. Medical Center News*

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Nov. 29-Dec. 4, Honolulu. Annual Convention, June 26-July 1, Dallas. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 69th Annual Scientific Meeting, Nov. 16-19, 1975, Miami. SMA, 2601 Highland Ave., Birmingham, Ala. 35205.

La.-Miss. O. and O. Society, May 27-29, 1976, Point Clear, Ala. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501.

Tennessee Valley Medical Assembly, Oct. 20-21, 1975, Chattanooga. Clifton R. Cleaveland, M.D., chairman, 960 E. Third Street, Chattanooga, TN 37403.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 9-12, 1975, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 108th Annual Session, May 3-6, 1976, Jackson. Charles L. Mathews, Executive Secy., 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson. 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, Secy., P.O. Box 128, Sumner 38957. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. A. K. Martinolich, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Reginald P. White, Secy., East Mississippi State Hospital, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, April, June, August, October, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., Jefferson Davis Memorial Hospital, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. D. Stanley Hartness, Jr., Secy., 314 Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lec H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn. Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 1004 Jackson Ave., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. G. O. Spencer Jr., Secy., 425 Hospital Dr., Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, May, July, September, November. Thomas R. Singley, Secy., Doctors Plaza, Suite 208, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Smith, Secy., No. 1 Medical Blvd., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m. Magnolia Motor Motel, Vicksburg. Martin E. Hinman. Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.



The President Speaking

"Malpractice Insurance"

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

THE PROBLEMS related to malpractice insurance have been widely discussed in the popular press as well as in professional journals. We all know that malpractice insurance is unavailable to some physicians and is increasingly costly to others. We know something of the proposed solutions including arbitration, legislation which would adjust statutes of limitations to a more reasonable and realistic time element, a ceiling on settlements and judgments, medical injury compensation patterned on the principal of Workmen's Compensation, alteration of the contingency fee systems and to the informed consent problem. These are valid approaches to the problem and we as Mississippi physicians must pursue them.

On the other hand I think we must take a long look at ourselves. It seems to me that several observations ought to be made about the uniqueness of the Mississippi physician. Unlike our colleagues in some other states, we can still get malpractice insurance. It is more costly but it is still available—why is that? I am inclined to believe that there is in our life style a genuine concern for people as well as for the diseases from which they suffer. What I am suggesting is that "an ounce of prevention is worth a pound of cure." Litigation is expensive whether it is legitimate or not. I suspect that much illegitimate litigation has its origin, not in the physician's lack of medical knowledge and technical skills, but in a lack of his human skills. Many routine diagnostic and therapeutic procedures are mysterious and undignified to the average patient. He simply does not know what is going on. If his confusion is compounded by haughtiness and ill temper on the part of office, hospital, or medical staff, he is surely prepared to believe the worst about the care he receives.

What can we as Mississippi physicians do to minimize malpractice suits? It is easy to point a finger at the grasping consumer, at a few lawyers who practice at or beyond the fringe of professional ethics, or at insurance companies who raise their premiums to prohibitive levels. It also solves nothing. What can we as physicians do? In addition to meticulous attention to providing the best possible quality health care in the diagnosing and treatment of disease, we also need to be alert to the human dimension of the doctor-patient relationship. Human skills have been defined as the ability to listen with the "inner ear," that is to hear not only the words people use but to be attuned to their feelings and to the intensity with which they are held. If our patients believe we really care about them as persons we have not only added a significant dimension to the healing process, we have also eliminated a significant factor in malpractice claims. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVI, NUMBER 7
JULY 1975

EDITORIALS

We Will Remember You—R.B.K.

Mississippi medicine has lost one of its most dedicated and effective spokesmen.

Rowland B. Kennedy died unexpectedly at his Clinton, Mississippi, home on June 7, 1975, and to all who knew his love and devotion to the medical community his death represents a great loss.

Rowland was the first executive secretary of the Mississippi State Medical Association. He liked to recall how he spent his first day on the job locating the association's "office" in various members' automobile trunks. Later he saw the association go through three building programs at its location on Riverside Drive in Jackson.

Rowland served on many important AMA advisory committees and became known on the national medical scene through his efforts on behalf of organized medicine. He was advisor, speechwriter, and confidant to 22 presidents of the Mississippi State Medical Association. Recently, in his position as president of the Central Mississippi Health Planning Council, he was appointed to an important U. S. Department of HEW advisory committee charged with the responsibility of drafting regulations to implement the new National Health Planning and Resources Development Act.

Rowland loved to write and the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION which he served as managing editor from 1960 to 1972 is indebted to him for its beginning and standing in the medical journalism community.

Rowland jokingly said that he was the "eye, ear, leg, and nose man of the physicians of Mississippi." He was—and for that and many other good reasons we will remember you—R.B.K.

CHARLES L. MATHEWS
Executive Secretary

Medico-Legal Briefs

PODIATRIST ENTITLED TO HEARING BEFORE DENIAL OF STAFF PRIVILEGES

A podiatrist was entitled to a hearing to protect his due process rights before a public hospital could deny him staff privileges, a federal appellate court in Georgia ruled.

The podiatrist had applied for membership on the staff of a county hospital. His application was denied on the basis of the bylaws of the County Hospital Authority and of the medical-dental staff. The bylaws permitted staff membership only to full-practice physicians and duly-licensed dentists. Podiatrists were not full-practice physicians because they were limited in practice to the foot and leg and could use only local anesthetics.

Before denying him staff privileges, the executive committee of the medical-dental staff invited the podiatrist to attend one of its meetings. He did so and requested that the executive committee discuss changing its bylaws to permit him to have staff privileges. After the podiatrist passed out literature and answered questions, the committee decided to recommend that no change be made in the staff bylaws.

Claiming that his exclusion from the staff was a violation of his equal protection rights, the podiatrist brought an action against the Hospital Authority. A federal trial court denied his claim, and he appealed.

On appeal, the federal court rejected the podiatrist's equal protection claim because it was unable to equate the various branches of the healing arts that would be included. The podiatrist argued that all persons licensed to practice the healing arts were members of one class. The court said it could not de-

termine whether podiatrists were unfairly discriminated against as a class.

However, the podiatrist was entitled to a rehearing by the Hospital Authority and the medical-dental staff because the summary hearing had deprived him of his procedural due process rights. His right to engage in his occupation as a podiatrist was protected by due process requirements. He was entitled to a hearing, complete with notice and an opportunity to be heard, the court concluded.

In a separate opinion, one judge agreed with the majority opinion and emphasized that the reasonableness of the bylaws was subject to question. A primary issue was whether it was reasonable to deny patients of a podiatrist the essential facilities of a twentieth-century hospital. Before relegating podiatrists to practicing in a garret, there must be a rational basis for denying them access to modern hospital facilities, he said.—*Shaw v. Hospital Authority of Cobb County,* 507 F.2d 625 (C.A.5, Ga., Jan. 29, 1975)

Editor's Note: A prior decision in this case was reported in *The Citation,* Vol. 28, No. 12, p. 184.

NEW MEMBERS

BLANTON, TERRELL D., Jackson. Born Memphis, Tenn., April 18, 1938; M.D., University of Mississippi School of Medicine, Jackson, Miss., June 1962; Interned Portsmouth Naval Hospital, Portsmouth, Va., one year; otolaryngology residency, National Naval Medical Center, Bethesda, Md., 1966-70; elected by Central Medical Society.

BOOTH, WILLIAM H., JR., Holly Springs. Born Maben, Miss., Oct. 12, 1929; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1956; interned Baroness Erlanger, Chattanooga, Tenn., one year; surgery residency, University of Tennessee, 1959; surgery residency, Baroness Erlanger, Chattanooga, Tenn., 1969-70; surgery residency, St. Joseph Hospital, Memphis, Tenn., 1970-73; elected by North Mississippi Medical Society.

MONAGHAN, BROOKS, JR., Holly Springs. Born Amory, Miss., May 5, 1940; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1964; interned St. Joseph Hospital, Memphis, Tenn., one year; surgery residency, same, 1968-71; elected by North Mississippi Medical Society.

SHAALAN, MAHMOUD, Corinth. Born in Egypt, July 2, 1934; M.D., Cairo University, Egypt, 1957; interned, same, one year; pathology residency, Mercy Catholic Medical Center, Philadelphia, Pa., 1969-71; pathology residency, the Hospital of University of Pennsylvania, Pa., 1971-72; pathology residency, UMC, Jackson, Miss., 1972-73; elected by Northeast Mississippi Medical Society.

WEEKS, CHARLES T., Vicksburg. Born Rochelle, Ill., March 22, 1940; M.D., University of Illinois College of Medicine, 1966; interned Good Samaritan Hospital, Phoenix, Ariz., one year; orthopaedic surgery residency, Hines-Shriners, Loyola University, Chicago, Ill., 1967–69; orthopaedic surgery residency, Tulane University, New Orleans, La., 1972-73; elected by West Mississippi Medical Society.

PERSONALS

THOMAS J. ANDERSON of Laurel, president of the Mississippi Academy of Family Physicians, was a guest speaker at the annual convention of Mississippi Licensed Practical Nurses' Association in Laurel.

JACK A. ATKINSON of Brookhaven, MSMA president, was guest speaker at the ninth annual convention of the American Association of Medical Assistants, Mississippi Society, in Jackson. JAMES P. SPELL of Jackson gave the invocation.

OTTIS G. BALL of Jackson has received subspecialty board certification in nuclear medicine awarded by the American Board of Radiology. Dr. Ball is with The Radiological Group at Miss. Baptist Hospital.

WILLIAM O. BARNETT of Jackson and UMC presented a paper and served as a panelist at the Alabama chapter, American College of Surgeons meeting in Point Clear, Ala.

VICTOR T. BAZZONE of Gulfport announces the relocation of his office for the practice of neurological surgery to Suite 408, Courthouse Plaza.

ERWYN E. FREEMAN and PAUL B. WELCH have joined the Children's Medical Group of Jackson for the practice of pediatrics at 800 Carlisle St.

James D. Hardy of Jackson and UMC was elected president of the American Surgical Association at the May meeting in Quebec. Dr. Hardy also accepted an award "for contributions to education, research, and service in American surgery" at Creighton University in Omaha.

Harold K. Hudson of Tupelo announces the relocation of his office to Tupelo Ear, Nose and Throat Surgical Clinic at 618 Pegram Drive.

John F. Jackson of Jackson and UMC attended the National Symposium on Genetics and the Law in Boston.

Sewell P. Kepner has associated with the Associated Medical Center at 139 Kirkwood Street in Picayune for the practice of general medicine and surgery.

Wayne T. Lamar of Oxford announces the association of Donald Newton Lyerly for the practice of orthopaedic surgery at 2168 South Lamar Avenue.

Nathan B. Lewis of Vicksburg has retired after 21 years of service as medical director of Kuhn Memorial State Hospital. He will continue his private practice at 1022 Monroe Street.

L. L. McIntire has joined the staff of the Lucius Olen Crosby Memorial Hospital in Picayune. Dr. McIntire is a radiologist.

Richard C. Miller of Jackson and UMC presented a paper at the University Hospitals of Cleveland, Ohio, residents' reunion.

Henry P. Mills, Jr., of Jackson announces the removal of his office for the practice of ophthalmology to 215 St. Dominic Medical Offices.

Tom H. Mitchell of Vicksburg received a plaque of appreciation from the governing board of Mercy Regional Medical Center at a special dinner given by the Sisters of Mercy to honor Dr. Mitchell as he left Mercy to become executive director of the Mississippi Foundation for Medical Care in Jackson.

Joe R. Norman and Guy D. Campbell of Jackson attended the annual meeting of the American Lung Association in Montreal. Dr. Campbell, who chaired the committee to select the Trudeau Medal recipient and serves on the ALA Board of Directors, also attended the American Thoracic Society annual session.

Donald Rayner of Gulfport, president of the Coast Counties Medical Society, was a guest speaker at the spring meeting of the Orleans Parish Medical Society held in Biloxi.

James R. Russell of Laurel announces the relocation of his practice of ophthalmology from Laurel Eye Center to the Medical Arts Building, 1203 Jefferson Street.

Leo J. Scanlon of Vicksburg attended the 1975 Diagnostic Cytology Symposium at Silver Spring, Md.

Jackson Medical Associates, P.A., announces the association of G. Boyd Shaw and Thomas E. Wilson, III, and the removal of their offices to Suite 200, Medical Plaza Building, 1600 North State Street.

The Simmons Clinic for Women, P.A., of Jackson announces the relocation of offices to 1030 N. Flowood Drive.

Robert R. Smith of Jackson and UMC presented a paper at the annual meeting of the Research Society of Neurological Surgeons in New Haven, Conn.

Glen C. Warren of Jackson has associated with Charles L. Neill, Walter R. Neill, and Lucien R. Hodges for the practice of neurological surgery at Suite 414, Medical Arts Building.

UMC Presents M.D. Degree to 101 Graduates

One hundred and one medical students received the M.D. in University of Mississippi Medical Center commencement ceremonies in May marking the first time graduating seniors in the School of Medicine have numbered more than 100.

U. S. Senator John C. Stennis was speaker for the exercises.

Donald Lee Roberts, Jr., of Long Beach received the prestigious Waller S. Leathers Award as the medical graduate with the highest academic average. A Millsaps alumnus, Dr. Roberts will intern at Charity Hospital, L.S.U. Division, New Orleans, La.

In addition to Roberts, who graduated summa cum laude, other medical students who received their degrees with honors were George Ellis Abraham, II, of Vicksburg and Charles Ray Robertson of Meridian, both of whom graduated magna cum laude.

Christopher Riddell Jones of Inverness, Walter Lee Bourland, Jr., of Tupelo, Terry Lynn Kilgore and David Tedrick Rigdon, both of Gulfport, graduated cum laude.

Chancellor Porter Fortune conferred 197 degrees in the May ceremony. Other graduates included 28 for the master of nursing, 37 for the bachelor of science in nursing, 15 for the B.S. in physical therapy, seven for the Ph.D. and nine for the M.S. in the health sciences.

The physical therapy students are the first state trained graduates in their field. They completed two years at a college of their choice and took the last two years of instruction at the Medical Center.

Dr. Mary Margaret Murphy, assistant professor of pediatrics (psychology), Dr. Arthur H. Dohlstrom, professor of nursing, and Dr. Faustena Blaisdell, professor of nursing and head of the nursing school's graduate program, all retiring at the end of the current academic session, received citations during commencement ceremonies recognizing their years of service to the University.

Dr. Markov Joins Med Center Faculty

Dr. Angel Markov has joined the University of Mississippi School of Medicine faculty as instructor in medicine.

Vice Chancellor Dr. Norman C. Nelson announced his appointment, effective April 1, following action of the Board of Trustees of Institutions of Higher Learning.

Dr. Markov completed a fellowship in medicine at the Medical Center before joining the faculty.

A native Bulgarian, he earned the B.E.E. degree at the University of Sofia, Sofia, Bulgaria, and the M.D. degree at the Catholic University of Louvain, Belgium, in 1972.

Before doing a residency at the University of Mississippi Medical Center, Dr. Markov was a research associate at the University of Rochester, Rochester, N. Y., the New Jersey College of Medicine, Jersey City, N. J., and the Catholic University of Louvain.

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

WALLACE LABORATORIES
CRANBURY, NEW JERSEY 08512

Introducing: The Director of the Mississippi PSRO

The Mississippi PSRO has moved into Phase II; it became fully operational in binding or meaningful review as of June 1, according to Dr. Tom H. Mitchell, executive director of the Mississippi Foundation for Medical Care.

Dr. Mitchell became fulltime director of the program on June 1, after having served as chairman of the Subcommittee to Develop Plan of Implementing PSRO in Mississippi. He was formerly medical director of the Street Clinic in Vicksburg and a practicing family physician.

He reported that there were 7 pilot hospitals in the program. The first hospital will come under Phase II review in July and the staff hopes that by the end of the month there will be 19 hospitals operational.

Dr. Mitchell outlined his hopes and concerns for the PSRO. His first objective is to use the law to benefit patients and to improve the quality of care. Secondly, he wants to assist physicians and hospitals in setting up their review program to meet the federal requirements. The third objective is to contain medical costs by insuring proper utilization of services.

When asked how the PSRO program will affect the M.D. in the hospital, Dr. Mitchell replied, "We're asking for documentation of the care he's rendering. If a physician is practicing good medicine and properly documenting the care rendered, he will be unaware of the functioning of the PSRO."

He also pointed out that each physician would rotate and serve on the review committee. The workload should average out to be about one additional hour a month. Studies have shown that the review physician will be directly involved in review of care of only about 20 per cent of patients admitted to the hospital.

The major problem encountered so far has been the shortage of qualified personnel to serve as review coordinators. In most hospitals, registered nurses or registered records administrators perform these duties, he said.

Large hospitals will have their own review systems, but smaller hospitals will form units in order to have enough physicians for adequate review.

In the area of confidentiality, Dr. Mitchell said that it will be better protected or assured under the PSRO. No charts will leave the hospital with the patient's name on them; everything will be coded. Profiles to be generated will be sent to the specific hospital or physician involved and nowhere else.

In regard to the punitive aspects of the program, he pointed out that the program will study patterns of care, not specific cases. If a physician consistently shows something different from patterns of care exhibited by his peers, his case will be referred to



Dr. Tom H. Mitchell, executive director of the Mississippi PSRO, discusses his concerns and goals for the review organization which has moved into Phase II, meaningful review.

his local review committee. Committee members will discuss the matter with the physician and urge him to participate in continuing medical education courses related to the problem. Physicians will have every protection under the law, Dr. Mitchell added.

Continuing medical education will be tied into profile evaluation studies. The PSRO education committee will work with the MSMA medical education committee and the continuing education division of the University Medical Center, he said.

Dr. Mitchell pointed out that the program will require validation of the diagnosis, that is information must be in the record to establish the diagnosis. Admission notes must be on the chart within the first 48 hours or payment from federal funds will not be made.

In continued stay, progress notes must be written with regularity and there are certain essential elements in the criteria that must be performed for each diagnosis.

The Mississippi criteria are measuring sticks, he said. They were developed by first going to the national specialty organizations for recommendations. The staff then reviewed data accumulated by the Mississippi EMCRO program. These findings were put together and referred to statewide specialty panels of physicians for review and recommendations. The criteria will not be static, however.

Some 75 per cent of physicians contacted accepted assignment to the specialty panels. "I am extremely pleased with the cooperation and enthusiasm we have gotten from physicians in the state," said Dr. Mitchell.

The PSRO staff at the Jackson office will eventually include about 20 people and some 50 review coordinators in participating hospitals will be on the payroll, the executive director stated.

Dr. Mitchell received his M.D. degree from Tulane University, completed internship at Southern Baptist Hospital in New Orleans, and did a two year residency in general practice at Mercy Hospital-Street Memorial in Vicksburg.

He is a member of AMA, MSMA, West Mississippi Medical Society, American and Mississippi Academy of Family Physicians. He was certified by the American Board of Family Practice, by written examination, in 1972.

R. B. Kennedy Memorial Neurology Fund Established

The Rowland B. Kennedy Memorial Neurology Fund has been established at the University of Mississippi Medical Center in memory of the former executive secretary of the Mississippi State Medical Association.



Mr. Kennedy

Mr. Kennedy died unexpectedly at his home in Clinton on June 7, 1975.

He held the position of MSMA executive for 22 years and in this capacity led in the development of many programs now executed by the association. Mr. Kennedy also helped develop the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION and served as the first managing editor of the publication.

In 1972 he was appointed executive secretary of Central Mississippi Health Planning Council. He was recently appointed to the Secretary of HEW's Task Force for Development of Regulations for Implementation of Public Law 93-641—The National Health Planning and Resources Development Act of 1974.

Contributions may be sent in care of the Rowland B. Kennedy Memorial Neurology Fund, University Medical Center, 2500 North State Street, Jackson 39216.

UMC Professors of the Year Named

Dr. William O. Barnett and Dr. Dennis O'Callaghan are clinical and preclinical professors of the year at the University of Mississippi School of Medicine at the Medical Center.

UM Medical Alumni Chapter president Dr. Frank W. Bowen of Carthage presented the awards for teaching excellence during the chapter's annual meeting at the Mississippi State Medical Association convention in Biloxi.

Senior medical students select the clinical professor of the year, and sophomore medical students name the preclinical awardee. The Medical Alumni Association presents the coveted awards.

Dr. Barnett, UMC professor of surgery, has been on the faculty since the Medical Center opened in 1955. He served seven years on the clinical faculty and joined the full-time faculty in 1963.

From 1963 to 1974, when the program became the Division of Continuing Health Professional Education, Dr. Barnett chaired the UMC postgraduate medical education committee. He served six years as coordinator for continuing education for Mississippi Regional Medical Program.

Member of many professional organizations, he is chairman of the American College of Surgeons committee on applicants, District 3 of Mississippi, and has served as vice-president of the Southeastern Surgical Congress.

The Tuscola native is author or coauthor of nearly 100 scientific publications.

An Ole Miss graduate, Dr. Barnett got his medical certificate at the then two-year University of Mississippi School of Medicine and the M.D. degree at the University of Tennessee.



Dr. William O. Barnett is clinical professor of the year at the University of Mississippi School of Medicine.

Dr. O'Callaghan is preclinical professor of the year for the second consecutive year.

Associate professor of microbiology at UMC, the associate editor of the *Journal of the Mississippi Academy of Sciences* has authored or coauthored 21 scientific publications.

Dr. O'Callaghan got the B.S. degree at Loyola University, New Orleans, and the Ph.D. in microbiology-virology at the University of Mississippi Medical Center in 1968. He was a postdoctoral research fellow and assistant professor of biochemistry at the University of Alberta School of Medicine, Edmonton, Alberta, Canada, before joining the Mississippi faculty in 1971.

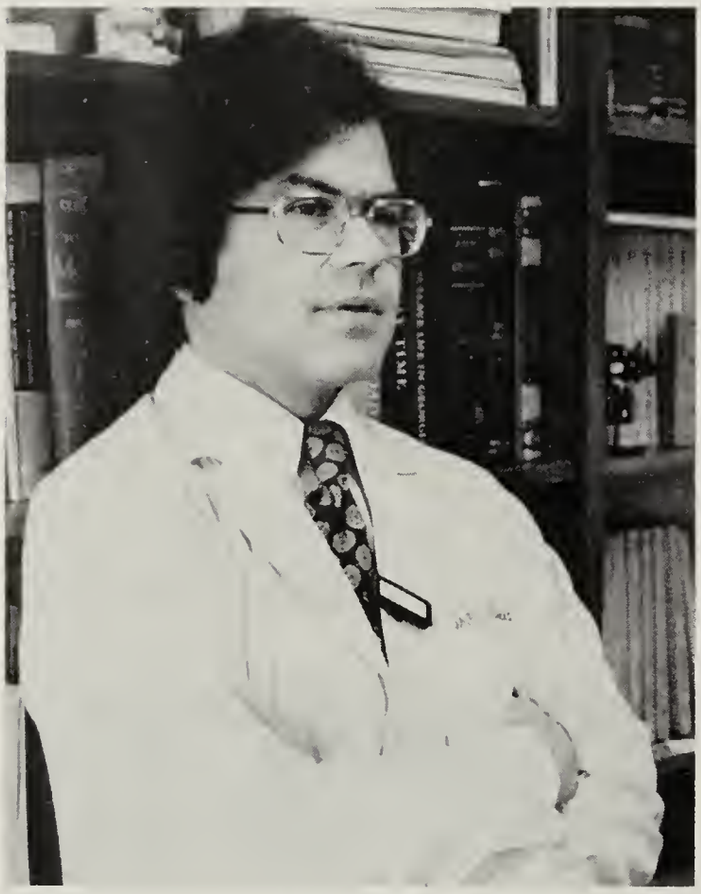
Past winners of the preclinical and clinical professors of the year awards are Dr. W. Forrest Hutchison and Dr. Nell Joyce Ryan, 1972; Dr. Robert D. Sloan and Dr. Carl G. Evers, 1973; and Dr. Bernard J. Dreiling and Dr. Dennis J. O'Callaghan, 1974.

Physicians Are Tested for Glaucoma



Dr. Samuel B. Johnson, Jackson ophthalmologist, is checking the eyes of one of the 400 physicians attending the state medical meeting recently. The Mississippi Society for the Prevention of Blindness sponsored the glaucoma screening. Dr. Johnson, with the cooperation of the Mississippi Ear, Nose and Throat Association and the Mississippi Society for the Prevention of Blindness, also taught a course in tonometry for non-ophthalmologists during the convention, giving family physicians an opportunity to learn to use the tonometer. As chairman of the MSPB Medical Advisory Committee, Dr. Johnson and the Prevention of Blindness Society recommend that the test for glaucoma become part of every routine physical examination.

Dr. Boronow Gets National Recognition



University of Mississippi Medical Center faculty member Dr. Richard Boronow is one of three nationally-known physicians who spoke during the American College of Obstetricians and Gynecologists "parade of professors" during the college's annual assembly in May. The ACOG program committee selected Dr. Boronow, Dr. John I. Brewer of Northwestern University Medical School, and Dr. Howard Ulfelden of Harvard Medical School to recognize their contributions to obstetrics and gynecology. Dr. Boronow, professor of obgyn and acting chairman of the department, lectured on endometrial cancer at the May meeting in Boston.

Dr. McDonnieal Named Blues Vice-Chairman

Dr. S. H. McDonnieal of Jackson and Lowery A. Woodall of Forrest County General Hospital, Hattiesburg, were elected to serve one-year terms as vice-chairman and chairman, respectively of Blue Cross and Blue Shield of Mississippi.

Other highlights of the annual directors meeting in Jackson included the announcement by George Butler, president, that almost $231 million was processed into the state's health care economy in 1974. This represents a dollar increase of 27 per cent in the reimbursement of claims for regular subscribers and others covered under government programs administered by the Mississippi Plan. Some 1.2 million Mississippians are served through the Blue Cross and Blue Shield Plan, Medicare and Medicaid.

Benefits paid to hospitals and doctors for members' health care totalled over $57 million. This represented the processing of 532,000 hospital and doctor bills and covered 612,000 days of hospital care.

In the administration of hospital claims under Medicare, the Plan processed 262,400 claims in 1974 with benefits of over $78 million for the Department of Health, Education and Welfare.

Payments processed for the Mississippi Medicaid Commission came to over $88 million represented by more than 5.5 million different claims.

At year end, membership enrollment stood at more than 560,000. "Public confidence in the voluntary health care system as manifested by membership gains is very gratifying," notes Mr. Butler.

Service to subscribers and providers has been the continuing emphasis of the Plan. A highlight of progress in 1974 was the organization of district offices in Hattiesburg, Greenville and Jackson to provide more information and personal service to members in all parts of the state.



Dr. S. H. McDonnieal, at left, is pictured with Lowery A. Woodall at the annual directors meeting of Blue Cross and Blue Shield of Mississippi.

In other action taken at the meeting, special tribute was paid to John D. Holland for his service during his 5-year tenure as chairman. Holland will continue to serve on the executive committee. The Plan by-laws place a 5-year limit on the chairman's term.

Wm. K. Ray of the Northwest Mississippi Regional Medical Center, Clarksdale, was elected to the Board. Special recognition was given to C. B. Read

of Lexington for his service to the Plan while a member of the Board.

Other board members in addition to Woodall and McDonnieal are T. W. Crowley, Brookhaven; Reuben S. Johnson, Meridian; Fred C. Lavender, Macon; Paul J. Pryor, Jackson; Dr. G. Spencer Barnes, Columbus; Dr. R. E. Caldwell, Baldwyn; Dr. Stanley A. Hill, Corinth; Dr. Lyne S. Gamble, Greenville; Dr. Louie F. Wilkins, Jr., Brookhaven; T. L. Crosby, Picayune; Shouphie Habeeb, Vicksburg; John D. Holland, Jackson; Marx Huff, Jackson; F. H. Nance, Cleveland; and W. O. Stanley, Jackson.

UMC Researchers Study Thyroid Hormones

Pediatric endocrinologists at the University of Mississippi Medical Center have discovered that human breast milk contains a significant amount of all thyroid hormones.

In studies supported by the National Foundation March of Dimes and directed by Dr. J. M. Montalvo, the investigators removed the thyroid of a baby monkey and allowed it to breast feed from birth. The monkey received no supplemental hormones, yet never showed signs of brain damage and revealed symptoms of a thyroid deficiency only when weaned from the mother.

Dr. Montalvo reported on the finding at the Atlanta, Ga., meeting of the Endocrine Society.

In an earlier study, the UMC scientists and investigators from the Mayo Clinic found that cord blood from normal fullterm newborns showed low levels of Tri-iodothyronine or T3 when measured at one week. Measuring again at one month, they found that the T3 had increased to normal adult levels.

The rise to normal levels took longer for premature babies.

Results of the research, published in *Pediatric Research,* July 1973, indicate that T4 or thyroxine may not convert to T3 in children as it does with adults.

Investigators also believe that many of the problems of prematurity—the difficulty in maintaining body temperature and higher incidence of mental retardation—can be traced to the slow rise to sufficient amounts of T3.

Medical Assistants Hold Annual Convention



The Mississippi Society of the American Association of Medical Assistants held its ninth annual convention April 18-20 at the Holiday Inn North in Jackson. The convention was hosted by Central Chapter and Mrs. Carol Smith of Brandon was general convention chairman. Shown from left are Dr. Guy Campbell of Jackson, advisor to the Mississippi society; Ms Laura Lockhart, AAMA president-elect and national representative to the Mississippi convention; Dr. Richard Burman of Gulfport, advisor to the Mississippi society; and Ms Gladys Lamb, retiring Mississippi president.

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UMC Med Student of the Year Named

George Ellis Abraham, II, is recipient of the 1975 Senior Medical Student of the Year Award, announced during the state medical convention and presented Honors Day at the Medical Center by the University of Mississippi Medical Alumni Chapter. Senior class medical students selected the recipient in "appreciation and recognition of those qualities of dedication, preparedness, leadership, and skills most admired and desired in a physician." The Vicksburg native, a member of Alpha Omega Alpha and Phi Kappa Phi, dean's scholar, and Book Award winner in the UM School of Medicine, will intern at University Hospital.

D.S.A. Presented to Dr. Robert E. Schwartz



Dr. Robert E. Schwartz of Hattiesburg is the recipient of the Mississippi Lung Association's first Distinguished Service Award. In recognition and appreciation for leadership and service, Dr. Schwartz was presented an inscribed silver tray at the recent MLA Annual Meeting in Jackson. Dr. Schwartz's long-time dedicated service to the association includes president of the Tuberculosis Association for 10 years, 1945-55; Member, Board of Directors and Executive Committee for nearly 45 years; and Mississippi's Representative Director, National Board of Directors for 20 years.

Nurse Practitioner Training Offered

If a child is asked, "Who peers down your throat with a flashlight and makes you say ahhhhhh, hits your knee with a funny hammer, and listens to your heart?" chances are he'll answer, "my doctor."

But future generations of Mississippi youngsters might well say, "my pediatric nurse practitioner." They'll be talking about graduates of the University of Mississippi Medical Center pediatric nurse associate program, one component of the family health nurse associate program. The second component, which will prepare R.N.'s as adult health nurse practitioners, is scheduled to begin in September.

The pediatric course is open to registered nurses with two years professional experience. Graduate pediatric nurse practitioners (PNPs) work closely with physicians in private practice, in public health, and in comprehensive health centers.

They are trained to evaluate total child health care needs, do general physicals, and to treat minor common childhood illness.

In states where PNPs have been working for some years (there are about 1,200 nationwide), studies show they have increased the number of patients seen in a doctor's practice by one third. The same studies show that patients like the idea of being cared for by both doctor and nurse practitioner, according to Linda Pearce, director of the two-part program.

Students learn in a variety of health care delivery systems, seeing children in both rural and urban settings.

"Personal career rewards are great," says Mrs. Pearce. "Graduates usually see an immediate increase in their pay scale, and they have the personal satisfaction of knowing they have a vital role in direct health care."

The component in adult health teaches the same evaluation and treatment skills as the pediatric course.

It, too, is open to R.N.'s with two years professional experience. Students may take one or both. If they take both, they can become family health nurse practitioners, prepared for an expanded role in the care of both children and adults.

Prospective students should contact Mrs. Pearce, School of Nursing, University Medical Center, 2500 North State Street, Jackson, Miss. 39216. The family health nurse associate program is supported in part by funds from the Division of Nursing, NIH.

Medical Center Adds New Faculty

Six new faculty members will fill associate and assistant professor and instructor posts at the University of Mississippi School of Medicine.

Vice Chancellor Dr. Norman C. Nelson announced their appointments following action of the Board of Trustees of Institutions of Higher Learning.

Dr. A. Wallace Hayes will join the faculty August 1 as associate professor of pharmacology and toxicology. Currently an associate professor at the University of Alabama, where he's been on the faculty since 1968, Dr. Hayes got his A.B. degree at Emory University and his M.S. and Ph.D. degrees at Auburn University. From 1966 to 1968, he was a research associate at Vanderbilt Medical Center and a postdoctoral fellow with the U. S. Public Health Service in Nashville.

New assistant professors at UMC are Dr. Paul E. Edwards, family medicine, Dr. Jefferson E. Hollingsworth, surgery, and Dr. W. Boyce White, family medicine.

Dr. Edwards, who joined the faculty April 1, had been in the private practice of medicine in Columbus since 1961. He earned the B.S. degree at Millsaps College and got the M.D. degree from the University of Mississippi School of Medicine in 1960.

Dr. Hollingsworth completed residency training at Stanford Hospital, Stanford, Calif., and joined the UMC faculty May 1. Former clinical associate with the National Heart and Lung Institute, Bethesda, Md., he got a B.S. degree from the University of Mississippi and the M.D. degree from Tulane University. Dr. Hollingsworth did an internship and residency at Duke University Hospital, Durham, N. C.

Dr. White, who earned the B.S. degree at Ole Miss and the M.D. degree at the UMC School of Medicine, had been medical director at Ellisville State School since December 1972. At UMC since April 1, he interned at Confederate Memorial Medical Center in Shreveport, served as a Naval flight surgeon in Pensacola, and from 1962 to 1972 was in private practice at Laurel.

Effective May 1, Dr. John E. Hall and Dr. Nick C. Trippodo are UMC instructors in physiology-biophysics. Both had been postdoctoral fellows at the Medical Center since 1974.

Dr. Hall was a predoctoral fellow and graduate teaching assistant at Michigan State University before coming to Mississippi. He got the B.S. degree at Kent State University and the Ph.D. degree at Michigan State.

Dr. Trippodo was a teaching assistant and predoctoral fellow at the University of Texas Graduate School of Biomedical Sciences at Galveston, where he got the Ph.D. degree in 1974. He earned the B.S. degree at Stephen F. Austin State University, Nacogdoches, Texas, and the M.S. degree at Colorado State University, Ft. Collins, Colo.

UMC Gets "After Surgery" Machine



The new Jobst pressure machine the American Cancer Society gave the University of Mississippi Medical Center through Mississippi Regional Medical Program helps reduce swelling in the arms of patients who've had radical breast surgery. UMC Vice Chancellor for Health Affairs Dr. Norman C. Nelson, left, demonstrates the equipment with Mrs. Roy Sims, ACS state coordinator for the "Reach to Recovery" program, as volunteer patient. Onlookers are Ms. Elsma Cliburn, nursing service staff member, and Dr. T. D. Lampton, MRMP coordinator.

Dr. Nigam Appointed to Pediatrics Staff

Dr. Sarvesh K. Nigam has been appointed assistant professor of pediatrics at the University of Mississippi School of Medicine.

Vice Chancellor Dr. Norman C. Nelson announced the appointment, effective July 1, following action of the Board of Trustees of Institutions of Higher Learning.

Dr. Nigam will complete a two-year fellowship at the Jewish Hospital and Medical Center of Brooklyn, N. Y., before coming to Mississippi.

The new appointee has done residencies at the Jewish Hospital and Medical Center, Safdarjang Hospital in New Delhi, India, and Mulana Azad Medical College, Delhi, as well as an internship at Medical College Hospital in Jabalpur, India.

Dr. Nigam earned the M.B.B.S. degree at Medical College, Jabalpur, and holds D.C.H., M.D., and E.C.F.M.G. degrees from Delhi University.

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Mississippi Hosts Newborn Course



More than 400 health professionals from across the nation came to Jackson in April for the 20th annual convention of the American College of Nurse-Midwives. Participants in a pre-convention neonatology workshop jointly sponsored by ACNM, the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine, and Mead-Johnson were, from left, Dr. Marshall H. Klaus, professor of pediatrics, Case Western Reserve; Ms. Ginnie Crandall, certified nurse-midwife, Washington, D. C.; Dr. L. Stanley James, professor of pediatrics, Columbia Presbyterian Medical Center; Dr. Alfred Brann, Jr., associate professor of pediatrics, University of Mississippi School of Medicine, and chief of the division of newborn medicine, and Dr. John E. Rawson, assistant professor of pediatrics, the University of Mississippi School of Medicine, and director of the Newborn Center.

Medical Center Adds Clinical Services Wing



Construction is underway on the new University Medical Center clinical sciences wing, to be located across the UMC service road on the east side of the Medical Center complex. The $7,500,000 addition, the first totally supported by state appropriation, will provide long-needed space for five clinical departments: obstetrics-gynecology, surgery, medicine, neurosurgery, and psychiatry. The new wing will require two calendar years for completion.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white bond paper with a standard typewriter.

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10, but when justified to the Editors, additional references will be considered for publication. Each will be critically examined, and only valid, primary references will be published. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript separately from the text.

Reprints may be obtained at cost plus shipping charges from the association and should be ordered prior to publication. The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*

Ninth Annual Renal Seminar Held



Topic for the ninth annual kidney disease seminar at the University Medical Center was "pathogenesis and treatment of kidney stones." Among faculty members were, from left, Dr. John P. Elliott, Jr., president, Mississippi State Urological Society; Dr. Herbert G. Langford, UMC professor of medicine; Dr. W. Lamar Weems, UMC associate professor of surgery (urology) and chief of the Division of Urology; Dr. Birdwell Finlayson, professor of surgery, University of Florida College of Medicine, Gainesville; Dr. John D. Bower, UMC associate professor of medicine and director of the artificial kidney unit; and Dr. John E. Howard, professor emeritus of medicine, the Johns Hopkins University School of Medicine, Baltimore. Sponsors were the Kidney Foundation of Mississippi, the University of Mississippi School of Medicine Departments of Medicine, Surgery (urology), and Pediatrics, the artificial kidney unit, and the Division of Continuing Health Professional Education.

Clinical Anesthesia Course Scheduled

A two-day course entitled "Recent Advances in Clinical Anesthesia," sponsored by the Department of Anesthesiology of New York University Medical Center, will be held on Sept. 27 and 28, 1975, at the Medical Center, 550 First Avenue, Manhattan. Dr. James E. Cottrell, assistant professor of anesthesiology, is course director.

The course is designed to assist clinical anesthesiologists in improving or updating clinical skills through theoretical and practical lectures and demonstrations. Applications of new management and care concepts will be stressed. Annotated abstracts of all subjects presented will be distributed in advance to all registrants.

The course is approved for 13 hours of credit in Category I for the Physician Recognition Award of the AMA and is cosponsored with the New York State Society of Anesthesiologists, Inc. Tuition is $160; for residents in training, $80. Further details are available at the Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York, N. Y.; telephone (212) 679-3200, Ext. 4027.

UMC Course Draws Family Physicians



Primary care physicians studied diseases of the nervous system and discussed when surgery is needed to treat the diseases in a three-day neurology/neurosurgery intensive course at the University of Mississippi Medical Center. Participants included, seated, from left, Dr. Charles A. Marascalco, Vicksburg; Dr. John Estess, Hollandale; and, standing, Dr. Edgar E. Bobo, Pearl; and Dr. Lloyd Z. Broadus, Purvis.

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

■ AUGUST 1975

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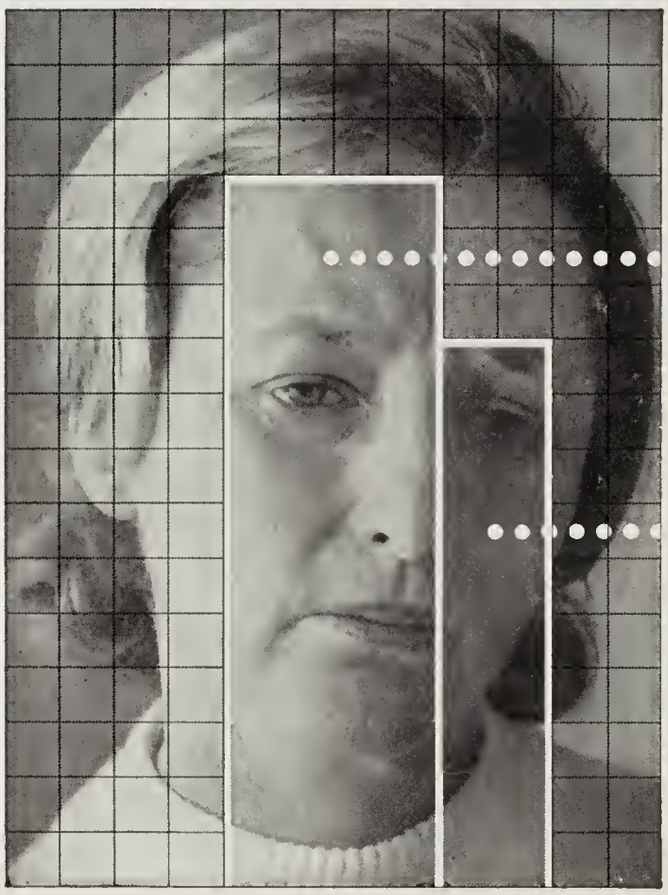
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This Month . . . Proceedings of the House of Delegates. Constitution and By-Laws

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Proceedings of the House of Delegates

107th Annual Session
May 5-8, 1975
Biloxi, Mississippi

THE 72ND ANNUAL SESSION of the House of Delegates was convened during the 107th Annual Session of the Mississippi State Medical Association, in pursuance to lawful notice given, on May 5, 1975, in the Top of the Sheraton, The Sheraton-Biloxi, Biloxi, Mississippi, at 9:00 o'clock in the morning by Dr. J. T. Davis of Corinth, president. The invocation was spoken by the Rev. Randall Perry, associate pastor of First Baptist Church in Gulfport.

After extending greetings, Dr. Davis presented the vice speaker, Dr. C. D. Taylor, Jr., of Pass Christian, and the speaker, Dr. Walter H. Simmons of Jackson, who assumed the chair. Dr. James P. Spell of Jackson, chairman of the Reference Committee on Credentials, reported the presence of a quorum of 125 registered and seated delegates in accordance with Section 3, Chapter V, By-Laws of the association.

ANNOUNCEMENT OF REFERENCE COMMITTEES

Reports of Officers and Board of Trustees
- Andrew K. Martinolich, Jr., Bay St. Louis, Chairman
- Wendell B. Holmes, McComb
- William H. Preston, Jr., Booneville
- Ellis M. Moffitt, Jackson
- Austin P. Boggan, Decatur

Medical Practices
- Richard C. Miller, Jackson, Chairman
- William E. Weems, Laurel
- Whitman B. Johnson, Jr., Clarksdale
- David L. Clippinger, Gulfport
- Lawrence H. Brisco, Tupelo

Constitution and By-Laws
- Tom H. Mitchell, Vicksburg, Chairman
- W. Lamar Weems, Jackson
- Mary J. Ward, Corinth

Rules and Order of Business
- John R. Lovelace, Batesville, Chairman
- Larry H. Day, Hattiesburg
- Joseph R. Henry, New Albany

Credentials
- James P. Spell, Jackson, Chairman
- Frank M. Davis, Corinth
- Henry B. Tyler, Jackson

APPOINTMENT OF TELLERS AND SERGEANTS-AT-ARMS

The three vice presidents were designated as tellers. They are:
- Whitman B. Johnson, Clarksdale
- W. B. Hunt, Grenada
- Paul H. Moore, Pascagoula

REPORT OF THE REFERENCE COMMITTEE RULES AND ORDER OF BUSINESS

To assist the speaker and vice speaker in the orderly conduct of the proceedings of this House of Delegates, your Reference Committee on Rules and Order of Business makes the following recommendations:

Conduct of Business: Under the By-Laws, the business of the House must be conducted according to *Sturgis Standard Code of Parliamentary Procedure,* and the speaker and vice speaker should prescribe the order of business as set out in the By-Laws. To insure proper recording of the transactions, all delegates recognized should identify themselves. Except for distinguished visitors and those having official capacity in the association, unanimous consent should be obtained for extending the privilege of the floor to nonmembers of the House of Delegates. The report of the Reference Committee on Credentials should constitute the formal and official roll call of the House.

Reference Committees. The purpose of reference committees is for affording all members of the association an opportunity to discuss their views on matters under consideration by the House of Delegates.

Reports. All reports and resolutions presented should be referred to the appropriate reference com-

mittee by the chair immediately after their presentation, the only exception being those which are of such a nature as to require no further consideration and are, therefore, ready for decision by vote of this House. Reports published in the *Handbook of the House of Delegates* are considered to have been formally presented and should be referred to appropriate reference committees by the chair. Debate should be reserved on all such presentations until such time as the reference committees conduct formal hearings and when they report to the House.

Resolutions. To avoid burdensome tasks upon the reference committees and to insure that all members have adequate opportunity to discuss their views, the House should permit no introduction of resolutions after the present meeting except for (1) matters of an emergency nature, the validity of such emergency to be determined by majority vote, (2) matters relating to a scientific section of scientific work, and (3) proposed amendments to the Constitution and/or By-Laws which would then lie on the table for one year.

The report of the reference committee was adopted.

SPECIAL REMARKS

The speaker recognized Mr. Tom Russell of the Sheraton-Biloxi staff, who briefly addressed the House of Delegates.

ADOPTION OF TRANSACTIONS

On motion by Dr. Stanley A. Hill of Corinth, seconded by Dr. Ellis Moffitt of Jackson, the Transactions of the 71st Annual Session of the House of Delegates, 106th Annual Session of the association, May 6-9, 1974, published in Volume XV, Number 8, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, August 1974, were adopted.

REMARKS OF THE SPEAKER

Dr. Walter H. Simmons: Welcome to the 107th Annual Session of the Mississippi State Medical Association. Our able staff has made their usual excellent effort for your convenience and comfort and I hope you will find them to your satisfaction this year.

New delegates are frequently confused by the procedure by which this body operates. The meeting is conducted according to *Sturgis Standard Code of Parliamentary Procedure*. Quoting from this volume, "The heart of the task is a procedure which will focus consideration on the right issues and lead to a resolution of these issues according to the views of the majority of the group." I am fortunate in having as vice speaker Dr. C. D. Taylor, Jr., an excellent parliamentarian. If a parliamentary question arises, one of us should be able to give the answer or look it up in Sturgis without too much delay. We will make mistakes but they will be honest ones. I certainly hope it will never appear to any of you that either of us has taken unfair advantage due to our positions.

Certainly I do not wish to stifle constructive debate. Our democratic process requires full discussion on the matter before us and *each* of you delegates has your opportunity to have your say. It should be emphasized, however, that our system of reference committees allows the full "in depth" discussion. At these reference committee meetings, any member of MSMA—not just you delegates—has the opportunity to speak. And by unanimous vote of the specific reference committee, *any* individual—not just a member of MSMA—may be allowed to be heard. I urge you to attend these reference committee meetings and I certainly discourage your taking the time of this body to discuss a subject Thursday which was "thrashed out" Monday at a reference committee meeting that you failed to attend.

The blue badge that each of you delegates wears has a special meaning of distinction. You have been chosen to represent your respective component medical society because of your integrity and your interest in organized medicine. May you represent them well. Many years ago a bit of philosophy that I often find helpful came to me—from where, I do not recall. In seeking the answer to a medical problem —political, ethical, or other—ask yourself the question, "Will it help the patient?" If the answer is yes, act affirmatively with the problem.

Last year in my "Remarks of the Speaker" I quoted from The Preamble of the Constitution of the Mississippi State Medical Association which appears inside the front cover of your program. To me those words have an unusual depth of understanding, compassion, and idealism. I'm going to quote them again, "That more may live longer in the richness and comfort of health; that pain, suffering, and disease may be eradicated to the extent made possible by scientific medical knowledge; that the standards of the medical profession may be maintained on the highest plane of honor, we dedicate ourselves as physicians through this association." Let us proceed with this meeting in a constructive democratic atmosphere.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered the remarks of our speaker, Dr. Walter H. Simmons. We believe that many times we are forgetful of the duties our speaker and vice speaker are called on to perform. Dr. Simmons has served us with distinction and with fairness to all. We commend both our speaker and vice speaker for the outstanding manner in which they have conducted the business of this House of Delegates.

The report of the reference committee was adopted.

PRESENTATION OF DISTINGUISHED GUESTS

The speaker presented the following distinguished guests:

Mr. George Butler, President, Blue Cross-Blue Shield of Mississippi.

Mr. Bob Wilkerson and Mr. Bill Norcoss, Mississippi Insurance Agents Association.

Mr. G. Milton Case, Chairman, Public Health Committee, Mississippi House of Representatives.

Mrs. Sally Ball, President, Mississippi Nurses Association.

Mr. Sam Cameron, Vice President, Mississippi Hospital Association.

Mrs. Elizabeth Fulgham, Governor's Office of Comprehensive Health Planning.

Mr. Davis Richards, Blue Cross-Blue Shield of Mississippi.

Mr. Warren Edwards, Blue Cross-Blue Shield of Mississippi.

Mr. Aaron Johnston, Blue Cross-Blue Shield of Mississippi.

Dr. E. William Rosenberg, Acting Dean, University of Tennessee School of Medicine.

Mr. Merrill Hicks and Mr. C. J. Sanders, University Medical Center student delegates.

Mr. Mack Dryden, *South Mississippi Sun.*

Mrs. Patsy Douglas, Executive Secretary, Central Medical Society.

ANNOUNCEMENT OF NOMINATING COMMITTEE

Following a recess for caucuses by association districts, the Nominating Committee was announced:

James V. Ferguson, Greenwood, District 1.

John R. Lovelace, Batesville, District 2.

William H. Preston, Booneville, District 3.

William B. Hunt, Grenada, District 4.

Joe M. Ross, Jr., Vicksburg, District 5.

George L. Arrington, Jr., Meridian, District 6.

Larry H. Day, Hattiesburg, District 7.

David R. Steckler, Natchez, District 8.

C. D. Taylor, Jr., Pass Christian, District 9.

Dr. Taylor was elected chairman of the committee which conducted an open meeting on May 7, 1975, and posted the nominations for the information of all members in addition to submitting a written report of nominations to the House of Delegates.

ADDRESS OF THE PRESIDENT

The speaker declared the House of Delegates in open session, and the president, Dr. J. T. Davis, delivered his address. The address has been published separately in Volume XVI, Number 7, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, July 1975.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee commends our president, Dr. J. T. Davis of Corinth, for his timely and informative address to this House of Delegates. Dr. Davis has served us with distinction and foresight and we know that the physicians of Mississippi join us in an expression of deep appreciation to him for his outstanding and dedicated service to the Mississippi State Medical Association.

The report of the reference committee was adopted.

SPECIAL ADDRESS

Dr. Malcolm C. Todd of Long Beach, Calif., president of the American Medical Association, addressed the House of Delegates.

REPORT OF THE DELEGATES TO AMA

This reporting covers the 123rd Annual Convention at Chicago, June 22-27, 1974, and the 28th Clinical Convention at Portland, Oregon, Nov. 30-Dec. 4, 1974. Your delegation is indebted to our president and other officers and members who participated in these conventions and worked with us.

Chicago Annual Convention. A change in the method of electing AMA Trustees, a definitive policy statement on PSROs, the need for additional safeguards to preserve the confidentiality of medical records, and new recommendations which affect the relationship between hospitals and hospital medical staffs were among the important items approved by Delegates at the 123rd Annual Convention in Chicago.

HOUSE OF DELEGATES / Continued

Meeting for a total of 19 hours and 38 minutes, the House acted on 66 reports and 137 resolutions for a total of 203 items of business.

The House approved bylaws changes which replace the "slot method" of electing trustees by the "simultaneous election of candidates to several positions of equal rank," in which all candidates run for board vacancies on a single ballot.

Under the new method, trustees for full, three-year terms are elected first, followed by the selection of trustees to fill unexpired terms. Election of the AMA president-elect, vice-president, and speaker and vice-speaker of the House remains on a separate basis. Delegates selected Max Parrott of Portland, Oregon, as president-elect.

Speculation over possible changes in PSRO policy by the House dominated the attention of those attending the convention, including the media.

During its day-long hearing on Monday, June 24, Reference Committee A considered two reports and 25 resolutions bearing on the issue, and estimated that 64 speakers addressed themselves to PSRO.

But on Wednesday, the Delegates—cognizant of the hours of debate devoted to PSRO at Anaheim last December and in New York City last June—overwhelmingly voted (202 to 24) to terminate debate after a few minutes.

Then the House adopted a substitute resolution on PSRO proposed by the reference committee, whose members emphasized that the resolution provides the association with a "clear-cut, definitive position which cannot be misunderstood by anyone inside or outside this House of Delegates." The resolution:

—Instructs the Board of Trustees to seek constructive amendments to the PSRO program, particularly in potentially dangerous areas such as confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW.

—Directs the AMA to continue efforts to achieve legislation which allows the profession to perform peer review according to established medical philosophy and the best interests of the patient.

—Emphasizes that state associations which elect non-compliance with PSRO are not prevented from doing so by the new policy, but urges such associations to develop effective non-PSRO review programs embodying the principles endorsed by the profession as constructive PSRO alternatives.

The new policy also provides that in the event that the PSRO program does, in fact, adversely affect patient care or conflict with AMA policy, then "the Board of Trustees (will) be instructed to use all legal and legislative means to rectify these shortcomings."

Two statements on national health insurance were adopted after lengthy debate. One calls on the Board of Trustees to cooperate with state associations "to attempt to devise mechanisms mutually acceptable to the private medical and insurance communities which will ensure the provision of health insurance coverage through the purchase of private health insurance, and to seek means to secure favorable Congressional and public support for their adoption."

During discussion, it was pointed out that the addition to the NHI policy does not affect AMA support for Medicredit, but is intended to stimulate new health insurance mechanisms. The second resolution calls on the AMA and component associations to work to detach "any national health insurance program from the controlling intrusions of existing PSRO laws and regulations."

The House adopted two resolutions bearing on drugs. One directs the AMA to continue its support of the pharmaceutical industry in efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy. The other resolution directs the AMA to "exert all efforts to amend or repeal the Kefauver-Harris" drug amendments of 1962, which gave the FDA broad new powers in drug manufacturing and marketing, and which critics of the FDA contend has tended to stifle the developing and marketing of new drugs in the United States.

The House went on record as being opposed to certain bills in Congress which would replace the federal "Health Professions Educational Assistance Act" which expired June 30. Under the bills, comprehensive health planning programs would be replaced with public utility type bodies which would control certain aspects of health education and health care delivery, and medical licensure. An amended resolution adopted by the House directs the Board of Trustees to mobilize AMA membership in opposition to offensive sections of the proposed legislation, and take strong actions on other fronts.

In other actions affecting physicians and the government, and other third parties, the House:

—Directs the AMA to seek an extension of

from 30 to 90 days to respond to proposed health regulations printed in the *Federal Register,* and that government agencies using the *Federal Register* for rule-promulgating purposes be urged to hold public hearings on the merits of proposed legislation.

—Calls on the AMA to oppose the concept of claims rejection on the basis of "diagnostic admission" or "lack of medical necessity" without prior physician notification, and to recommend a peer review mechanism be established independent of the third-party carrier to review claim conflicts with such mechanisms to be established by existing medical foundations, medical societies or other independent peer review organizations.

—Requests the AMA to work with third parties to secure increased acceptance of the AMA uniform health insurance claim form, and urges state associations to encourage acceptance of the form by insurance commissioners, and, if necessary, through state legislation.

—Urges continued AMA efforts to prevent future imposition of government fee controls, and opposes the mandatory imposition of a "Healthcard" as the payment mechanism under the Administration's national health insurance plan, and instead, reaffirmed the right of the physician to bill patients directly.

The House adopted two reports bearing on confidentiality of medical records. Report I of the Council on Medical Service describes a wide-ranging series of proposals to enable the medical profession and insurance companies to "maintain the confidentiality and security of patient information." Report S of the Board of Trustees notes that the Council on Legislation is developing model legislation as a guide to possible state legislation to preserve confidentiality, and that a model bill should be ready for consideration by the House at the 1974 Clinical Session in Portland, Oregon.

The House adopted the 104-page "Report on Physician-Hospital Relations, 1974," compiled by the Council on Medical Service and its Committee on Private Practice. An update of an earlier report made in 1964, the 1974 version contains 14 specific recommendations to cope with problems developing between some hospitals and their medical staffs. Among other things, the recommendations are aimed at protecting medical staffs against unilateral action by hospital governing boards relative to staff bylaws, rules, and regulations. The report was considered by the MSMA House of Delegates at our 106th Annual Session, May 1974.

Two informational reports dealing with possible guidelines for housestaffs in developing contracts in institutions in which they serve generated considerable discussion before Reference Committee C. Among those testifying were medical students, residents, faculty members, hospital directors, and members of the AMA's Board of Trustees and Council on Medical Service. Because of the importance and the complexity of the issues involved, the two reports, plus a revised report submitted by the Intern and Resident Business Session during the convention, were referred to the Board of Trustees for further study and consultation with appropriate groups. Delegates directed the Board to report back at the 1974 Clinical Session.

The House adopted a resolution calling for the AMA, through appropriate committees and councils, to assure due process for medical students, and requested a further report at the next clinical session.

Another resolution proposing guidelines for "Fair, Professional Relationships between Training Institutions and House Officers" (intended for inclusion in the essentials of approved internships, and residencies) was referred for further study and report back at the clinical session.

The House adopted a resolution calling on the AMA to encourage—and urging medical schools to implement—a series of lecture programs for students on the socio-economic aspects of medicine.

Portland Clinical Convention. A mandatory, special assessment of $60 for AMA members was approved by the House of Delegates at the 28th Clinical Convention in Portland. The assessment, effective Jan. 1, 1975, for AMA members excluding students, interns, and residents, was expected to improve immediate cash-flow problems and help build up depleted financial reserves. Rejecting a $90 dues increase proposed by the Board of Trustees, delegates instead called for a special committee of the House to study the dues issue and report back at the 1975 annual meeting.

The price of defending medical freedom can be high, but that price must be paid, AMA President Malcolm C. Todd, M.D., told delegates at the Clinical Convention in Portland.

Equating the "freedom that has made American medicine the most creative in the world" with the "very essence of professionalism cherished so highly by the nation's physicians," Dr. Todd pointed out that medicine's freedom, and hence its professionalism, are threatened.

HOUSE OF DELEGATES / Continued

Chief among the threats are various legislative proposals which would impose a compulsory national health insurance system, would make health care a public utility to "reduce each of us to the level of an electric wire or a telephone line," and manpower bills that would "imply indentured service in medical education."

Only a strong AMA can counter such threats and preserve professionalism, Dr. Todd emphasized, but "it is impossible for its strength to be any greater than its finances."

Therefore he issued a strong appeal to the House to support a $90 dues increase, or as an alternative, a special assessment.

While admitting that the AMA was not 100 per cent effective legislatively, he said that "No element in society has a perfect score. Any element has to set its sights not on the best of all possible worlds, but the best of all possible realities."

He said that if the AMA is to be effective in seeking a national health insurance plan that would "respect both public needs and professional competence" in countering overly-stringent health planning and manpower bills and in mitigating malpractice problems, then "it will need the money."

In assessing a mandatory $60 special assessment effective Jan. 1, the delegates acted to strengthen AMA finances.

The House was reminded that the association has operated at a deficit for four of the last five years and that cash reserves have been seriously depleted during that time. In addition, AMA finances in 1974 were adversely affected by inflationary pressures.

After almost six hours of comment and deliberation on Tuesday afternoon and Wednesday morning, the delegates adopted the $60 special assessment as a stop-gap measure.

The question of a dues increase was referred to a special committee of the House to be appointed by the speaker. The committee will make a comprehensive study of the AMA's financial priorities and capabilities and report to the House at the 1975 annual meeting.

In related actions the House strongly urged the Board of Trustees to restore in a "holding pattern" the structure of several councils and committees which were to have been eliminated and to maintain present publication schedules for *JAMA*, all specialty journals, and *Prism*.

The House also approved advertising as a legitimate function in AMA publications and urged that the present full and unrestricted advertising program in AMA publications continue pending further study and a report at the June meeting.

During a discussion of malpractice problems, the House adopted a recommendation calling for the Board to give "priority attention" to providing legal counsel and advice to AMA members and state societies in the event their professional liability insurance is not renewed.

The House also emphasized the necessity for state associations to seek legislative remedies for malpractice problems and directed that the AMA continue to cooperate with the medical liability commission.

A separation of the fall business meetings of the House and the scientific meetings will be permitted beginning in 1977.

Under bylaws changes adopted by the House in Portland, the House will hold its fall meeting separately in cities recommended by the Board and selected by the House, and the scientific session will hold regional meetings at other times during the year as deemed necessary by the Board and at cities selected by the Board.

The new format was devised to allow regional scientific programming. The scientific assemblies will continue to be held in conjunction with annual meetings, however.

The House adopted several recommendations which reaffirm the rights of all physicians including housestaff and medical students to due process. In related actions the House adopted as AMA policy the proposition that a student's academic records should be open to inspection so that he/she may profit educationally; and referred back to the judicial council for further study a report involving three cases of alleged violation of due process at the local level.

The House adopted a set of revised guidelines for housestaff contracts. The proposed guidelines as revised had been approved by the Council on Medical Education, the Board of Trustees, and the Council on Medical Service.

Delegates also adopted a Board report calling for strong programs of continuing medical education and peer review as alternatives to relicensure since "the difficulties inherent in relicensure clearly outweigh any potential benefits."

Specific recommendations include all possible encouragement and support for the AMA, constituent societies, JCAH, and other bodies in expanding CME programs; that the AMA give high priority to

enhancing and reviewing effective methods of continuing competence; that patient satisfaction should be included in performance evaluation; and that well-designed peer review programs be endorsed as an important component of performance evaluation. The House also stressed that evaluation of performance rather than knowledge per se is the best method of appraising competence in patient care.

In other actions related to physicians and hospitals and medical schools, the House:

—Adopted an amended resolution which urges that duplication of local peer review procedures be avoided; that medical audit or utilization protocols used in screening be limited to those which are demonstrated to be valid, reliable, and which do not add needlessly to cost; and that when local peer review groups recognize that a hospital medical staff has adequate medical audit and utilization procedures, that fact should be recognized by governmental agencies and JCAH.

—Adopted a Board report detailing legally approved methods for the exchange of information between and among medical societies and hospitals concerning a physician's hospital privileges or practice.

—And requested that a "comprehensive report" be presented at the 1975 annual meeting on questions and issues related to foreign medical graduates.

In other actions related to physicians and the government (and third parties), the House:

—Objected to language in insurance letters indicating the claims were "not medically necessary" since this encourages patients to decline to pay for services and is defamatory to physicians.

—Urged that medical intermediaries adhere strictly to regulations for reimbursement of chiropractors to those procedures defined in the regulations.

—Encouraged the acceptance and use by physicians of the AMA's Uniform Health Insurance Claim Form, and urged insurors to study the possible use of plastic "charge card" type identification cards for imprinting basic data on insurance forms.

—And urged the government to continue its present 55 m.p.h. speed limit for at least a one-year period noting that traffic fatalities have declined 14.8 per cent since the speed limit was imposed last year.

The House took a strong policy position against the use of human chorionic gonadotropin for use in weight reduction. The House further resolved "that the AMA warn our citizens about the potential danger of such a weight control program." Clinics utilizing chorionic gonadotropin have been established and widely advertised in various parts of the country.

The House adopted two reports that reaffirm AMA policy to encourage insurance coverage of the newborn from the moment of birth, urge the health insurance industry to offer coverage for obstetrical care and any complications, and recommend that the insurance industry—as well as government—offer such coverage on the broadest possible basis.

In other actions relative to physicians and the public, the House:

—Supported state legislation to regulate the practice of acupuncture. The new policy says acupuncture should only be performed in research settings by a physician or under the direct supervision of a physician.

—Reaffirmed AMA endorsement of the flouridation of water supplies.

—Adopted a judicial council report which holds that "It is not unethical for a physician to authorize the listing of his name and practice in a (community) directory for professional or lay use which is intended to list all physicians in the community on a uniform and nondiscriminatory basis. The listing shall not include any self-aggrandizing statement or qualitative judgment regarding the physician's skills or competence."

—Endorsed the right of a physician to dispense ampicillin-probenecid for gonorrhea patients, reflecting a judicial council opinion that physicians have a duty to protect the confidentiality of patients who contract gonorrhea.

—And adopted a substitute resolution calling for the government to develop adequate safeguards for the transportation and storage of hazardous materials such as radioactive materials.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered the reports of our delegates to the AMA, Drs. G. Swink Hicks and Joseph B. Rogers. This past year has been a year of issues and debate on the national medical scene. We commend our delegates for their work in the AMA House of Delegates on our behalf.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Organization and Duties—The Council on Scientific Assembly is a constitutional body of the House of Delegates charged with the responsibility of planning the annual session of the association to include all scientific activities, programming, and the scheduling of annual session events. The council membership consists of the chairmen and secretaries of the eight scientific sections and the secretary-treasurer of the association, a total of 17 members.

107th Annual Session—Planning and organization of the 107th Annual Session was initiated in the summer of 1974. The format has been changed this year to condense the meeting. *The final session of the House of Delegates will meet on Thursday morning rather than Thursday afternoon. To facilitate this, several of the eight scientific sections will be meeting simultaneously.* The schedule was also arranged so that there would be one afternoon completely free of planned activity, Wednesday, May 7. To the extent possible, conflicts in schedules and programming have been eliminated, although as a practical matter, such total elimination is not possible. In some instances, the council has requested and placed essayists from various specialty societies not represented in the Scientific Assembly before section audiences.

We are gratified that at the present annual session, 15 specialty societies have related or concurrent meetings with us. Four medical alumni groups have fraternal and social occasions, and various nonscientific but medically related bodies will meet during May 5-8. Added attractions this year include a Sunday afternoon program, "Arthritis Day," which is sponsored by the Mississippi Methodist Rehabilitation Center, the Arthritis Foundation, and the Mississippi Regional Medical Program. The Mississippi Sports Medicine Society will hold its organizational meeting and host a guest speaker during convention week. We continue to believe that providing for and encouraging these related meetings increases the attractiveness of the annual session to the membership and benefits attendance. We are glad to continue support of the Woman's Auxiliary concurrent annual session. The auxiliary will again host the hospitality booth on Sunday afternoon to greet and welcome convention goers.

Scientific and Technical Exhibits—Your council is grateful for the participation of our scientific and technical exhibitors in this 107th Annual Session of the association. Presentations in the scientific exhibit number over 20 this year. We urge every member and guest to view these educational exhibits and the technical exhibits.

Headquarters Hotel—The annual session will be held at the Sheraton-Biloxi for the fifth year. In 1976 the convention will return to Jackson and the headquarters hotel will be the new Holiday Inn Downtown.

The council is directing an extensive promotional campaign through the JOURNAL MSMA and the Blue Sheet to increase attendance at the annual meeting. The format and size of the annual session hand program is also being revised.

Expression of the Council—Your Council on Scientific Assembly is grateful for the support, cooperation, and assistance we have received in planning the 107th Annual Session of the association.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered the report of our Council on Scientific Assembly. We commend the council for its continued work to improve and streamline the annual sessions of the association. This has been an outstanding meeting.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Organization and Duties—The Council on Medical Service is a constitutional body of the House of Delegates, consisting of nine members, one from each association district, elected for terms of three years each. The council is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under the council's jurisdiction are assigned activities of the association in medical service, emergency service programs, medical care for the indigent, and the work of allied medical agencies and organizations.

The council is assisted by several committees. These embrace a range of subject areas to include maternal and child care, blood and blood banking, mental health, and nursing.

Committee on Nursing—The Committee on Nursing serves as the association's liaison committee with a similar committee of the Mississippi Nurses Association. The committee is working to implement the

expanded role for the RN as directed by the House of Delegates and authorized by statute. The MSMA-MNA Joint Practice Committee is serving in a consulting role to the Mississippi State Board of Health and Board of Nursing in developing standards and administrative procedures for the expanded role of the nurse. The committee notes the several programs available to the RN and leading to an expanded clinical role in health care delivery. The committee and council believe it should be stressed that in an expanded clinical role, the RN should function under supervision of a physician(s) and never function in an independent medical practice role.

Committee on Mental Health—The Committee on Mental Health met during the year to consider the organization of the new State Department of Mental Health as created by the 1974 Legislature and the House of Delegates directive that the association support legislation to modernize our current mental institution commitment laws. The committee has expressed concern that a non-M.D. director could be appointed to replace the current physician-director of the Department of Mental Health if he resigns. The director is appointed by the Board of the department. Legislation to modernize the state's commitment laws and to make the laws conform to recent judicial decisions was considered by the 1975 Mississippi Legislature. This legislation will be reviewed in other reports and the council recommends that pertinent portions of the legislation be brought to the attention of all Mississippi physicians.

Committee on Maternal and Child Care—The Committee on Maternal and Child Care continues its study of maternal deaths in Mississippi. During the year the committee completed study of all cases occurring in 1972 and a report on this has been prepared for publication in the JOURNAL MSMA. The committee's "Maternal Health Desk Cards," which serve as a handy reference source on maternity care, have been revised, published in a new format, and distributed to all hospitals in the state.

Other Council Activities—The council has considered other subject matter within its sphere of assigned interest and will present a supplemental report to the House of Delegates in this regard at the annual session.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

The report of the Council on Medical Service summarizes the activities of its separate committees on nursing, mental health and maternal and child care during the past year. The council's Committee on Nursing has worked diligently on developing standards and minimum requirements for implementation of the expanded role for registered nurses as authorized by legislation passed in 1974. The Committee on Mental Health has continued to monitor the formation and activities of the State Department of Mental Health as created by the legislature, in addition to considering legislation to modernize our statutory commitment procedures. The council's report recommends that pertinent portions of the legislation updating our commitment procedures be brought to the attention of our membership. The Committee on Maternal and Child Care has continued its invaluable study of all maternal deaths occurring in Mississippi. The reference committee took particular note of the fact that the committee's "Maternal Health Desk Cards" have been revised, published in a new format and distributed to all interested persons.

Your reference committee commends the Council on Medical Service and its various committees for their expansive and timely activities. We, therefore, concur with the council's report and recommendation and recommend their adoption.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT A OF THE COUNCIL ON MEDICAL SERVICE

The Council on Medical Service is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Within this context the council has reported the activities of its several constitutional committees during the 1974-75 association year in the *Handbook of the House of Delegates*. The council has considered other subject matters within its sphere of assigned interests and wishes to bring the following information and recommendations to the attention of the House of Delegates for such action as deemed appropriate.

1. *The Physician Assistant.* Definition and role of the physician assistant has been a matter before this House of Delegates since 1971. In 1971 the House of Delegates adopted the following policy guides in connection with physician assistants which were recommended by the council and Board of Trustees:

(1) "The adequately trained physician assistant is needed and the association should approve and support this field.

(2) "In conferring this approval and support, specific restraints on activities of physi-

cian assistants would be imposed and the physician assistant should occupy a dependent, supervised function, never functioning independently.

(3) "To qualify for association approval and support, physician assistants in Mississippi should meet stated training minimums and requirements.

(4) "The physician assistant should not be licensed but rather should be registered with the State Board of Health."

In 1972 and 1973 the House of Delegates reaffirmed support for training minimums and requirements for physician assistants and stated that the PA should work under the direct supervision of his physician employer. In 1974 the House of Delegates adopted the following recommendation of the council:

"The council recommends that the House of Delegates reaffirm its position on physician assistants (i.e., PAs not be licensed and work under the direct supervision of a physician) and further urge legislation in this regard to empower the physician members of the Mississippi State Board of Health to approve and certify a physician's employment of the physician assistant and to approve and certify proposed functions of the physician assistant as described by his physician employer. The use of the term "physician assistant" in this context refers solely to the new occupation being developed to assist the physician in delivery of personal care services."

Subsequent to the above, the Mississippi State Board of Health, on June 20, 1974, and Dec. 12, 1974, in recognition of the employment by some physicians of personnel called "physician assistants," adopted guidelines relative to the utilization of such personnel. In January 1975, the association sponsored legislation for consideration by the 1975 Regular Session of the Mississippi Legislature which would require the State Board of Health to certify and approve functions of the "physician assistant" in accordance with the policy statement adopted by the House of Delegates in 1974. The legislation did not pass.

Standards for educational programs preparing assistants to primary care physicians were adopted by the AMA House of Delegates in December 1971 having been developed jointly by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Society of Internal Medicine. These standards are now the basis of the "Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician" used by the AMA Council on Medical Education in accrediting such programs. Additionally, the Council on Medical Education of the AMA working with the American Academy of Orthopaedic Surgeons, the American Urological Association, and other national specialty groups has developed "Essentials" of approved educational programs for the assistant to physicians in distinct specialty areas.

Recommendation. Your council recommends that the association reaffirm its support for training minimums and requirements for physician assistants in accordance with "Essentials" of educational programs for physician assistants approved by the AMA Council on Medical Education and continue to urge statutory authority for the physician members of the Mississippi State Board of Health to approve and certify a physician's employment of a physician assistant.

2. *The National Health Planning and Resources Development Act of 1974 (Public Law 93-641)*

This program was passed by Congress on Dec. 19, 1975, and has been called by both proponents and opponents as the most important health legislation passed by Congress since enactment of the Medicare-Medicaid Programs. The act combines and expands the former functions of the Regional Medical, Comprehensive Health Planning, and Hill-Burton Programs. The act requires the secretary of Health, Education, and Welfare to issue "guidelines" concerning health planning policies. The guidelines will include standards for the "appropriate supply, distribution, and organization of health resources." "Health resources" are defined as health services, health professional personnel, and health facilities. The secretary of HEW is to consult with local and state planning agencies to be created under the act in developing his guidelines. However, the Congress has declared certain national health priorities within the act that are to be given priority consideration. These priorities include development of multi-institutional systems for coordination or consolidation of institutional health services, provision of primary care especially to rural and economically depressed areas, development of medical

group practices, utilization of physician assistants, development of multi-institutional arrangements for sharing of support services, promotion of facilities to achieve needed improvements in the quality of health services, promotion of preventive health care services, promotion of uniform cost accounting systems for health institutions, and development of methods for educating the general public concerning proper personal health care.

The act provides for the designation of health service areas within each state by the governor of the state. Governors are to designate such areas no later than May 3, 1975. The areas are generally to be composed of a population of from 500,000-3,000,000 persons and are to include, if possible, at least one center for the provision of highly specialized health services. Consideration is also to be given to present PSRO areas, regional planning areas, and state planning and administrative areas, all of which generally differ in each state. In each health service area, a health systems agency will be funded. The agency must be either a private nonprofit corporation or a public body with an independent governing board composed of a majority of consumers. At least one-third of the Board's members must be direct providers of health care. The health systems agency may establish subarea advisory councils representing parts of the agency's health service area to advise the governing body of the agency on the performance of its functions. The health systems agency (within guidelines established by the secretary of HEW) will be responsible for establishing and reviewing annually a health systems plan for meeting health needs of the area. Additionally, the health systems agency (within guidelines established by the secretary of HEW) will establish an annual implementation plan for approving grants to all applicants for funds under specified sections of the Public Health Service Act and various other health related programs funded through the Department of HEW. The health systems agency will also review the need for proposed new institutional services and recommend projects and priorities for modernization, construction, and conversion of medical facilities.

The act further provides for the secretary of HEW to designate an agency of state government chosen by the governor in each state to serve as a state health planning and development agency. The state agency is to conduct state health planning activities to include reviewing institutional health services and making findings as to the need for such services and coordination of planning activities of health systems agencies within the state. The state agency is to be advised by a statewide health coordinating council composed of a majority of consumers and appointed by the governor of the state. Sixty per cent of the council's membership is to be appointed by the governor from nominees submitted by the health systems agencies within the state.

Recommendation. Your council recommends that each member of the House of Delegates make known to their component society through discussion at meetings of the society the content and ramifications of the National Health Planning and Resources Development Act of 1974 presented in this report and urge the involvement of the society's membership in the implementation of this important act in Mississippi. We further recommend that the association closely monitor and publicize all aspects of the act's implementation in Mississippi.

3. *Modernization of Mississippi Medical Practice Act.* Your council has reviewed the Mississippi Medical Practice Act in the light of its clarity and effectiveness for regulating the practice of medicine in the 20th century. The act as it pertains to the definition of the practice of medicine was passed in 1882.

Recommendation. Your council recommends that the association urge the physician members of the Mississippi State Board of Health to work with the association and appropriate legal counsel to modernize the Mississippi Medical Practice Act and to seek appropriate legislation in this regard.

4. *Health Maintenance Organizations.* At the 1974 Annual Session, your council reported passage of the Health Maintenance Organization (HMO) Act of 1973 and recommended that the Association furnish leadership and guidance in defining the legal status of HMOs in Mississippi. Legislation was introduced during the 1975 Regular Session of the Mississippi Legislature to establish some basic regulatory standards for the HMOs to be administered by the state insurance commissioner. Unfortunately, the legislation failed to pass due in large part to a lack of interest among the membership.

Recommendation. Your council recommends that

the association reaffirm its prior position urging state legislation to regulate HMOs in Mississippi.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Supplemental Report A of the Council on Medical Service sets forth four separate recommendations as follows:

A. *Physician Assistants.* The council recommended that the association reaffirm its support for training minimums and requirements for physician assistants in accordance with "essentials" of educational programs for physician assistants approved by the AMA Council on Medical Education and continue to urge statutory authority for the physician members of the Mississippi State Board of Health to approve and certify a physician's employment of a physician assistant. Your reference committee considered this portion of the council's report in conjunction with the Council on Legislation's recommendation that the association not sponsor and seek the passage of legislation about which our membership may be divided in feeling. Consequently, we recommend that the association continue to support the concept of training requirements and standards for physician assistants and their certification by the physician members of the State Board of Health, but that we not sponsor such legislation at this time.

In discussion of the recommendation, Dr. G. Swink Hicks of Natchez made a substitute motion that, "this House of Delegates take a stand in opposition to training, employing, licensing or certifying physician assistants in the state of Mississippi."

Dr. Hicks' motion was seconded by Drs. Max Pharr and Richard C. Miller of Jackson. Speaking in support of Dr. Hicks' motion were Drs. J. Dan Mitchell of Jackson, Joseph Rogers of Biloxi, James K. Williams of Pascagoula, and W. Moncure Dabney of Crystal Springs. The speaker called for a vote on the substitute motion and it was adopted.

This portion of the report of the reference committee was adopted as amended.

B. *Health Planning and Resources Development Act of 1974 (Public Law 93-641).* This portion of the council's report recommended that each member of the House of Delegates make known to his component society through discussion at meetings of the society the content and ramifications of this far-reaching act and urges the involvement of the society's membership in its implementation in Mississippi. The council further recommends that the association closely monitor and publicize all aspects of the act's implementation in Mississippi. Your reference committee concurs in these recommendations.

This portion of the report of the reference committee was adopted.

C. *Modernization of Medical Practice Act.* The council recommends that the association urge the physician members of the Mississippi State Board of Health to work with the association and appropriate legal counsel to modernize our Medical Practice Act and to seek appropriate legislation in this regard. Your reference committee concurs with this recommendation.

In discussion, Dr. Joseph Rogers cautioned against opening the Medical Practice Act to amendments.

Dr. Samuel B. Johnson of Jackson then moved to amend the report by substituting the word "consider" for "seek." The motion was seconded by Dr. Charles R. Jenkins of Laurel and adopted.

This portion of the report of the reference committee was adopted as amended.

D. *Health Maintenance Organizations.* The Council recommended that the association reaffirm its prior position urging state legislation to regulate HMOs in Mississippi. Your reference committee also considered this recommendation in light of the Council on Legislation's report on the past history of such HMO regulatory legislation. Consequently, we recommend that the association continue to support the concept of statutory HMO standards and regulation but that we not sponsor such legislation at the present time.

This portion of the report of the reference committee was adopted.

The report of the reference committee was adopted as amended.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

1. *Background.* Based on approval of the Board of Trustees and the House of Delegates at the 1973 Annual Session of the association, the Council on Medical Education has proceeded to organize a program to accredit instate continuing medical education activities conducted by medical institutions and

organizations in Mississippi. The accreditation program has been approved by the AMA Council on Medical Education, and following AMA guidelines the council has developed "Guiding Principles for Continuing Medical Education in Medical Institutions and Organizations." The council has accredited three instate CME programs and several requests for accreditation surveys are pending at this time. CME programs accredited by the council meet Category I hour requirements for the AMA "Physicians Recognition Award."

2. *Accreditation of MSMA Annual Session.* The Council on Medical Education in furtherance of its goal to improve and strengthen voluntary programs for continuing medical education in our state has acted to accredit the scientific program for the annual session of our association. The scientific program for the 107th Annual Session has been accredited for 12 hours toward Category I requirements for the AMA "Physicians Recognition Award." The scientific program has also been accredited for 12 prescribed hours by the American Academy of Family Physicians.

The Council on Medical Education has provided a brief questionnaire to be completed by each physician attending the scientific sections that will serve two purposes. The questionnaire will solicit comments from those in attendance concerning the scientific program and seek suggestions for improving next year's program. It will also serve to document attendance at the scientific program and in this connection serve as a basis for establishing a mechanism to annually report to MSMA members their attendance at CME programs. The council hopes to establish this reporting mechanism during the 1975-76 association year. The council also plans to publish a directory of CME programs in Mississippi.

3. *Enlargement of Council on Medical Education.* The council has discussed the feasibility of enlarging its membership to obtain broader geographic and specialty representation. At this time the council is composed of three members elected from the north, central, and southern areas of the state. The council believes it would be advantageous to increase its membership to consist of one member from each association district and recommends that the MSMA By-Laws be amended for this purpose.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered the report of our Council on Medical Education. We commend the council for its work in continuing medical education. We note with appreciation the accreditation of this year's scientific program.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

The report of the Council on Medical Education recommended that the present membership of the council be expanded from the current three members to nine, one member coming from each of the nine association districts. The report further recommended an amendment to the MSMA By-Laws to accomplish this change in council membership.

The committee heard much discussion concerning the make-up of the council and how the membership should be drawn. It was the consensus of the meeting that where possible each specialty should be represented by membership on the council in order to provide for a broad spectrum of input and activities. Consequently, your reference committee recommends that the MSMA By-Laws be amended to provide for the election by each specialty section recognized in Chapter IV, MSMA By-Laws, of one member to serve on the Council on Medical Education for a period of three years each beginning at the 108th Annual Session in 1976.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

The following amendments to the MSMA Constitution and By-Laws were presented in open session at the 106th Annual Session and officially sent to each component society two months prior to the 107th Annual Session as required by Article XII MSMA Constitution which states:

> "The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been sent officially to each component society at least two months before the session at which final action is taken."

The proposed amendments would result in the following if adopted:

1. Provide that nominees for election of office attend one of past two or current annual sessions;
2. Provide for election of two trustees to the Board of Trustees from association District 5;

3. Provide that the president and immediate-past president shall be members of the Board of Trustees;

4. Provide that trustees and council members shall serve no more than two consecutive three year terms;

5. Provide that no member shall be eligible for election as a trustee who has served in that office two consecutive three year terms within the past six years;

6. Provide that no member shall be eligible for election to a council who has served on that council two consecutive three year terms within the past six years;

Amend Article VI—MSMA Constitution—General Officers—Section 3. ". . . The officers of this association shall be elected by the House of Delegates on the last day of the annual session following the adjournment of the general meeting, but no person shall be elected to any such office who has failed to attend *one of the past two or current annual sessions* and who has not been a member for the past two years."

On motion by Dr. J. Dan Mitchell of Jackson, seconded by Dr. Charles N. Floyd of Gulfport, the amendment was adopted.

Amend Article IX—MSMA Constitution—Board of Trustees. ". . . The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates and shall perform such duties as are prescribed by law governing directors of corporations and in the By-Laws of the Association. The Board shall consist of *12* members, one from each of the nine association districts *except association District V which is authorized two members,* elected for terms *of three* years each *and the president and immediate-past president.* A trustee shall not serve more than *two* consecutive terms *and no member shall be eligible for re-election to the Board of Trustees after serving two consecutive terms until that individual has been off the Board for at least six years.*

On motion by Dr. James O. Gilmore of Oxford, seconded by Dr. Frank Acree of Greenville, the following amendment was offered following the last sentence of the amendment—"However, the amendment shall not apply to present incumbents." The amendment to the amendment was defeated. Next, on motion by Dr. James L. Royals of Jackson, seconded by Dr. Robert S. Caldwell of Tupelo, the amendment was adopted.

Amend Chapter VIII—MSMA By-Laws—Board of Trustees—Section 1. ". . . The Board of Trustees shall be the executive and governing body of the association during vacation of the House of Delegates. It shall consist of *12* members, one from each association district *except association District V which is authorized two members,* whose terms of office shall be three years. A trustee shall not serve more than *two* consecutive terms. *No member shall be eligible for re-election to the Board of Trustees after serving two consecutive terms until that individual has been off the Board for at least six years. The president and immediate-past president of the association shall also serve on the Board of Trustees.* During vacation, the Board of Trustees shall exercise the powers conferred upon the House of Delegates by the Constitution and these By-Laws, provided that in the exercise of these powers thus conferred, the Board of Trustees shall neither consider nor act to contravene any action, mandate, or policy of the House of Delegates which may still be in effect."

On motion by Dr. Max Pharr of Jackson, seconded by Dr. Lawrence W. Long of Jackson, the amendment was adopted.

Amend Chapter IX—MSMA By-Laws—Councils—Section 1. ". . . Councils of the association shall be elected standing bodies of the House of Delegates, responsible thereto. There shall be a Council on Medical Service, a Council on Scientific Assembly, a Judicial Council, a Council on Constitution and By-Laws, a Council on Legislation, a Council on Budget and Finance, an Editorial Council, and a Council on Medical Education. A council member shall not serve more than *two* consecutive terms. *No member shall be eligible for re-election to a council on which he or she has served two consecutive terms until that individual has been off that council for at least six years."*

On motion by Dr. J. Dan Mitchell, seconded by Dr. John Egger of Drew, the amendment was adopted.

The report of the council was adopted.

RECOMMENDATIONS OF COMMITTEE TO STUDY COMPONENT MEDICAL SOCIETIES AND COMPENSATION OF ELECTED MSMA OFFICERS

Background. At the 106th Annual Session, the House of Delegates adopted recommendations that

a committee of the House be appointed to study: (1) methods of strengthening personal communication between the state and component societies; (2) compensation of elected officers of the association; and (3) methods of strengthening the component society as an organizational entity of the association. Subsequently, the president appointed a committee to include the chairmen of the Councils on Scientific Assembly and Medical Education, several of the component medical society secretaries, and Dr. Arthur A. Derrick of Durant as chairman.

Recommendations of the Committee. The committee met on Oct. 10, 1974, and arrived at the following recommendations, the first six of which have been forwarded to the presidents and secretaries of the component societies for their review and comment:

Recommendation No. 1—That MSMA conduct an annual orientation program for all component society officers, preferably in conjunction with the MSMA annual session. The committee feels that such a "workshop" or orientation program would better prepare all society officers for the conduct of their duties. The program would consist of such subjects as the relationship between component societies, MSMA and the AMA, parliamentary procedure and conducting meetings, services available to component societies, the responsibilities of component societies in the framework of organized medicine, the duties of officers, the organization of scientific programs, etc.

Recommendation No. 2—That the MSMA coordinate and cooperate with the component societies in arranging meetings or programs that would offer continuing medical education accreditation for those in attendance. The committee feels that a society program that provides CME accreditation would greatly enhance member attendance and interest.

Recommendation No. 3—That MSMA establish a "speaker's bureau" composed of authorities on such matters as practice management, business investments, malpractice, politics, taxation, etc., and that these speakers be made available to component societies upon request to present a program. Needless to say, the committee feels that the availability of such speakers to any component society upon request would enhance attendance and offer a valuable service to its members. The committee further feels that any expenses necessary to retain such speakers should be borne by MSMA and not the societies.

Recommendation No. 4—That MSMA provide clerical services to any component society that requests them. The committee is well aware of the fact that only one of the 18 component societies has a staff to provide administrative and clerical services. Consequently, component society officers are often forced to rely on their already overworked office personnel to provide secretarial and clerical services for the society. In view of this fact, the committee encourages each component society to call on the MSMA staff to provide clerical or administrative services whenever they are needed.

Recommendation No. 5—That MSMA provide all component society officers with a complete summary of actions by the House of Delegates following each annual session. The committee feels that it is very important for the component societies, and especially their officers, to be well informed about the activities of the association's policymaking body, and that such information is important to an officer in the conduct of his official duties.

Recommendation No. 6—That each component society hold an annual "legislative night" and invite all legislators in the society area to the meeting. The 1974 House of Delegates also recommended that each society conduct a "legislative night" for the purpose of discussing voting records and health care issues with their legislators. The committee strongly feels that such an activity would not only provide an interesting and informative program, but would greatly assist the medical profession's efforts in assuring the passage of sound and constructive health legislation.

Recommendation No. 7—That in accordance with Section 6, MSMA By-Laws, each MSMA trustee give an annual report at the winter meeting of the Board concerning his visits to the component societies within his respective association district in his capacity as the ". . . organizer and arbiter for the association district. . . ."

Recommendation No. 8—That the president, president-elect, vice presidents, and secretary-treasurer be reimbursed for travel expenses incurred in visiting the association's component societies.

Recommendation No. 9—That the president's "honorarium" be increased from $1,000 to $1,500.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered the report of this committee dealing with recommendations to strengthen our component societies and compensation of our elected officers. We note particularly in regard to the latter that recommendations of the committee are to reimburse our president, president-elect, vice presidents, and secretary-treasurer for travel expenses incurred in visiting the association's component societies and to increase the president's "honorarium" from $1,000 to $1,500. We concur in these and other recommendations of the committee.

The report of the reference committee was adopted.

REPORT OF THE BOARD OF TRUSTEES

Organization and Duties—The Board of Trustees is the executive and governing body of the state medical association during vacation of the House of Delegates. It is additionally charged with the duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties the Board shall have conducted five meetings during the 1974-75 association year and met daily during the annual session as required by the association's by-laws. Eight officers sit with the Board of Trustees at all meetings. They are the president, president-elect, immediate past-president, secretary-treasurer, speaker, vice speaker, and the two AMA delegates.

This annual report includes actions on matters referred to the Board by the House of Delegates and items relating to the management and policy functions which are among the Board's responsibilities.

Referrals From the House of Delegates—Matters referred to the Board of Trustees at the 106th Annual Session, 1974, and actions by the House requiring further consideration and implementation include:

Amendments to the MSMA Constitution and By-Laws—Amendments to the MSMA constitution and by-laws dealing with annual session attendance requirements for election to office, reapportionment of association districts, composition of the Board of Trustees, and tenure of Board and council members are "on the table" for action at the 107th Annual Session and are the subjects of a report from the Council on Constitution and By-Laws.

Address of the President—In his address to the House of Delegates at the 106th Annual Session, president Arthur A. Derrick recommended and the House concurred in appointment of a committee to study and report to the House of Delegates recommendations concerning compensation of elected officers of the association and methods for strengthening the component societies of the association as organizational entities. A special committee was formed for this purpose and its report will be presented to the House of Delegates.

Defining the Legal Status of Health Maintenance Organizations (HMOs)—Approval for the association to furnish leadership and guidance in defining the legal status of HMOs in Mississippi has been implemented and is the subject of a report from the Board concerning 1975 legislative activities.

Annual Registration of Physicians' Licenses—A recommendation that the Board study the matter of the association's supporting annual registration of physicians' licenses is the subject of a report from the Board concerning 1974 legislative activities.

MPAC Support of Local Candidate Committees—A recommendation that the Mississippi Medical Political Action Committee initiate and support local candidate committees during this year's legislative races is the subject of a report from the Board concerning MPAC activities.

MSMA Membership Dues Increase—Approval of a $25 increase in MSMA membership dues effective 1975 has been implemented.

Scheduling of 1976 Annual Session in Jackson—A recommendation to schedule the 1976 Annual Session in Jackson and thereafter meeting on the gulf coast in odd numbered years and in Jackson in even numbered years has been implemented.

Resolution No. 4—This resolution directed the establishment of a section on anesthesiology. The section on anesthesiology begins meeting at the 107th Annual Session.

Resolution No. 5—This resolution directed the association to support legislation to modernize admission laws to mental hospitals in Mississippi and is a subject in a report from the Board concerning 1974 legislative activities.

Resolution No. 8—This resolution urged moderation in increasing professional fees upon expiration of the Economic Stabilization Act on April 30, 1974. Such moderation has been

stressed in numerous publications to the membership from MSMA and the AMA.

CHAMPUS—The association enters its 19th year as fiscal administrator for CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). A 14-member physician committee serves as the review committee for the program. CHAMPUS continues to grow with an increase in claims and dollar volume during 1974. Based on program policies, CHAMPUS reimburses participating physicians at the 90th percentile of usual, customary, and reasonable charges in Mississippi.

Insurance Programs—The association continues to sponsor a hospitalization group program with Blue Cross and Blue Shield of Mississippi, general accident, disability, health and life groups with the Continental Casualty Company, and a professional liability program with the St. Paul Companies.

The Continental Casualty Company group programs are administered by Thomas Yates and Company of Jackson. Improvements in these contracts during the year as announced to all MSMA participants included a 20 per cent increase in term life benefits without extra cost and allotment of additional coverage under the disability overhead plan without proof of insurability.

The St. Paul professional liability insurance program underwent a major policy change during the past year reflective of the malpractice crisis that has occurred over the past several years. Effective in 1975 the St. Paul Company will only underwrite professional liability on a yearly claims reported basis and will offer a policy for claims not reported when the insured physician retires or ceases being insured by St. Paul. In prior years St. Paul has written professional liability insurance on an "occurrence basis" covering both claims reported and claims occurring during the policy period but not reported until later. In addition to this major change the malpractice insurance premium continues to increase.

The Board has acted to appoint a committee on professional liability insurance to study and recommend solutions to the malpractice crisis. The Board views the work of this committee as timely and important for the future of the practice of medicine and health care of the public in Mississippi.

Budget and Finance—The Council on Budget and Finance met in December 1974 and prepared the 1975 association budget which was presented to the Board in accordance with established procedure. The budget will be presented to the House of Delegates as a part of the annual report of the secretary-treasurer.

Legislative Program—The 1975 Regular Session of the Mississippi Legislature convened in Jackson on Jan. 6, 1975. The Council on Legislation met prior to the session for the purpose of organizing the association's legislative program. Other activities have included production of the weekly "MSMA Legislative Report," continuation of the Emergency Medical Care Unit at the Capitol. coordination of a physicians' legislative contact committee, and updating of the "health voting index" on each member of the 1972-75 Mississippi Legislature. The latter will become an important part of the Mississippi Medical Political Action Committee's (MPAC) local candidate support program to be conducted during this year's legislative races.

The association had a five-point legislative program for the 1975 Regular Session dealing with the following subjects: (1) Health Maintenance Organizations; (2) physician assistants; (3) a 28-day life span for CPD preserved blood; (4) mental hospital commitment procedures; and (5) upgrading of professional fees authorized under the Mississippi Medicaid Program. The association actively supported or opposed other legislative proposals before the 1975 Legislature. A full report will be made in this regard at the annual session.

Mississippi Foundation for Medical Care, Inc.—Based on directives from the House of Delegates, the MFMC sought and obtained funding as the "conditional PSRO" for Mississippi during the past year. Much work and planning by many Mississippi physicians preceded the Foundation/PSRO going operational the early part of 1975. Work has also proceeded on plans to establish a peer review program with all third party payors. Foundation membership increased during the past year and now totals 1,100 physicians. In October 1974 a mail ballot election of the MFMC Board was conducted by the membership.

The MFMC will hold an annual membership meeting in conjunction with the 107th Annual Session.

Experimental Medical Care Review Organization (EMCRO)—The association's EMCRO project, directed at developing a physician-sponsored system for evaluating the quality of medical care, has been phased into the activities of the Mississippi Foundation for Medical Care PSRO Program. The EMCRO

project which was funded initially in 1971 has served as a valuable research and development resource for the PSRO Program. Dr. Millard S. Costilow, principal investigator for the MSMA/EMCRO Program, serves as a director of the Mississippi Foundation for Medical Care.

Journal MSMA—The JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION concluded its 15th year of continuous publication in 1974. The thrust of the JOURNAL continues solidly around Mississippi medicine and the JOURNAL serves as the association's prime communication mechanism with the membership.

Total pages in Volume XV, 1974, were down from 1973 reflecting fewer national ads and our efforts to produce a smaller book for economical reasons. Local advertising continued to increase and a concerted effort is being made to continue this trend. Editorials and news about Mississippi medical activities were kept at their 1973 content levels.

Among other services the JOURNAL provides the membership are: complete program of the annual sessions; handbook and proceedings of the House of Delegates; and regular listing of component medical society officers and meeting dates.

The Board wishes to acknowledge special appreciation to the editors and Committee on Publications in the production of this vital membership service.

Mississippi Medical Political Action Committee (MPAC)—MPAC conducted its most successful membership recruitment drive during this past year and was officially recognized by the American Medical Political Action Committee for its efforts in this regard. A new monthly newsletter for all MPAC members called "MPAC Reports" was initiated during the year. The newsletter concentrates on the state and national political scene.

Based upon their past voting records and excellent support of organized medicine, MPAC elected to support those incumbent Mississippi congressmen who had more than token opposition in last fall's general elections. Each candidate was overwhelmingly reelected to office.

At the 106th Annual Session, the House of Delegates directed the organization and support of local candidate support committees in the 1975 Mississippi Legislative elections. MPAC is proceeding to organize this endeavor and a report will be made in this regard at the annual session.

Organization of the Board—Two new trustees, Drs. Joe S. Covington of Meridian, District 6, and Arthur A. Derrick of Durant, District 4, were welcomed to the Board during 1974-75. Officers of the Board during the year were Drs. James O. Gilmore, Oxford, Chairman; Everett Crawford, Tylertown, Vice Chairman; and Gerald P. Gable, Hattiesburg, Secretary.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received the annual report of our Board of Trustees. We commend the members of the Board for their diligent and outstanding management of the business affairs of the association.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT A OF THE BOARD OF TRUSTEES

Legislative Activities—Background. The 146th Session of the Mississippi Legislature convened in Jackson on Jan. 7, 1975, for its fourth and final 90 day regular session of the 1972-1976 term. The Council on Legislation held one meeting prior to the convening of the legislature and reported to the Board of Trustees at its December meeting in this regard. In accordance with prior directives of the House of Delegates, the council directed weekly publication of the Mississippi Medical Legislative Report and again operated an Emergency Medical Care Unit at the Capitol.

MSMA 1975 Legislative Program. In addition to monitoring all health-related bills which were introduced in the 1975 legislative session, the association had a four-point legislative program based on actions by the House of Delegates at the 106th Annual Session as follows: (1) set standards for and authorize the insurance commissioner to regulate HMOs; (2) provide for a 28-day life span for CPD preserved human blood; (3) modernize statutory commitment procedures to mental institutions; and (4) authorize the State Board of Health to certify and regulate physician assistants. In addition, due to the widespread inequities with the existing fees paid to physicians under the Medicaid Program, the council elected to sponsor legislation to change the basis for reimbursing physicians under the Medicaid Program. A summary of the current status of this legislative program is discussed below:

1. *Authorize Insurance Commissioner to Reg-*

ulate HMOs. This legislation was introduced as a result of the House of Delegates' approval of a resolution from West Mississippi Medical Society and the report of the Council on Medical Service urging the association to seek legislation which would set minimum operating standards for HMOs and authorize the insurance commissioner to regulate their ongoing operation. Following introduction, this bill was assigned to the House Insurance Committee where it died without being acted on. Several factors were involved in the insurance committee's failure to take any action on this bill; namely, the demise of the Street Clinic-Mercy Hospital HMO, and opposition from both the insurance commissioner and a vast segment of the insurance industry. Adding to the problem was the fact that few legislators are familiar with the HMO concept of health care delivery. In short, there was little, if any, real support for this legislation by members of the legislature or, for that matter, the medical profession. Your council firmly believes that this legislation is necessary to assure the solvency and quality of any proposed HMO, but until the public, the medical profession, and the legislature become more familiar with the HMO concept, there will be little chance of securing passage of this legislation. As a result, your council recommends that the association not actively pursue the passage of this legislation in future sessions, but that we continue to support the need for HMO standards and regulatory authority.

2. *28 Day Life Span for CPD Preserved Blood.* This legislation was introduced as a result of the House of Delegates' adoption of a resolution offered by West Mississippi Medical Society. The bill was subsequently passed by both the House and Senate and signed into law by the governor.

3. *Modernize Involuntary Commitment Procedures.* Pursuant to the House of Delegates' directive, the association worked with the House Public Health Committee in developing commitment legislation that would assure a patient's constitutional safeguards without imposing any additional burdens of time and liability on the examining physician. The bill subsequently passed both the House and Senate and was signed into law by the governor. Your council recommends that the association provide information to the membership regarding the new procedure as authorized under this law for admission and commitment of persons to our state mental institutions.

4. *Physician Assistants.* Based on actions by the House of Delegates at the 106th Annual Session, the council sponsored legislation to "empower the State Board of Health to approve and certify a physician's employment of a physician assistant and to approve and certify proposed functions of the physician assistant as described by his physician employer." Needless to say, there was a fairly large amount of controversy and ambiguity surrounding this matter among physicians, and unfortunately it surfaced during floor debate on the bill in the House. Although the association had sponsored this bill and it was a part of our legislative program, numerous legislators indicated that they had met with their physicians on the society or medical staff level and they had collectively expressed their opposition to this bill. Even though the measure ultimately passed the House, it was a "tainted" victory since it appeared that the association was at odds with certain of its membership. After passing the House, the bill ultimately died in the Senate Public Health Committee for lack of a clear mandate of support from the medical profession. The passage of legislation is a difficult process at best, even with a clear and unified voice of support, but in the absence of this unanimity and a clear mandate, it is impossible. It would appear from the actions surrounding this bill that the association and your council were directed to seek legislation with which a vast segment of the membership did not agree or support. In the future your council sincerely hopes that we will not attempt to seek the passage of legislation about which there is so much confusion and for which there is little if any support.

5. *Medicaid Physician Fees.* Although not directed by the House of Delegates to seek this legislation, your council decided to sponsor legislative changes in the existing statutory basis for reimbursing physicians under Medicaid and thereby alleviate a problem which has plagued many physicians since the enactment of Medicaid in Mississippi. A total of four bills were introduced in the House and Senate to eliminate the statutory language which restricts physician payments under Medicaid to the Blue Shield F-300 Surgical Schedule. Much information was distributed to the association membership regarding the need for this change. Special mailings were sent out detailing the justification for an increase. Numerous articles were highlighted in the "Blue Sheet" and *MPAC Reports* urging our members to discuss



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Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

this change with their legislators. Ultimately, one of the bills was reported out of committee in the Senate while three companion bills in the House all died in committee. After weeks of parliamentary maneuvers in the Senate, the remaining bill was amended to substitute the Blue Shield F-450 for the Blue Shield F-300 and finally passed and sent to the House. On three different occasions the House Public Health Committee failed to muster the necessary votes to report the bill out favorably and it ultimately died. Several legislators indicated that they had not been contacted by the physicians in their area about the need for this bill and consequently they felt no urgency regarding the need for its passage. Your council was indeed disappointed over the loss of this bill, especially in view of the fact that it had passed one House of the legislature; but its loss simply points out the fact that the success or failure of any legislation depends on us, the physicians, and how effectively we communicate our needs and problems to our legislators.

Other Legislative Activities. In addition to the four-point legislative program noted above, your council, working with the association membership, was successful in helping to secure the passage of several important health related bills during this session of the legislature. Among these were measures to redefine hospital records to exempt PSRO and utilization review records from judicial process (HB 558), increase the amount a medical student may borrow from the state (SB 2173), and several amendments to the medical practice act that would clarify the State Board of Health's authority in its administration. It should also be noted that we were the first state to enact the AMA's "Disabled Doctor Statute" to provide for the restriction of a license of any physician who labors under certain physical and/or mental disabilities as determined by a committee of his peers selected from the association membership (HB 487).

We were also successful in defeating measures which would have authorized optometrists to diagnose and use drugs, and several bills which would have required health insurance policies to cover chiropractors on a mandatory basis in addition to allowing their participation in the Medicaid Program.

During the 106th Annual Session, the House of Delegates directed the Board of Trustees to study the subject of annual registration of physician licenses by the State Board of Health and to make a recommendation to the House at the 107th Annual Session relative to this legislation. The Board gave much consideration to this matter at its December meeting, particularly in light of the fact that two such registration proposals had already been prefiled for the 1975 legislative session. Several legislators had indicated to the Board that there was widespread legislative sentiment for adoption of some type of annual license registration and that the only thing really in question was the amount of the registration fee that would be paid to the State Board of Health. It should be noted here that both of the prefiled license registration bills provided for an annual fee of $50. After having considered these facts, the Board elected to support the concept of annual license registration for accountability purposes only at a fee of $10 annually to be used exclusively to support administrative cost of the annual registration. The Board's decision to support this proposal was based primarily on three factors: (1) the need in Mississippi for annual listing of practicing physicians; (2) the fact that Mississippi was the only state that did not have some form of mandatory license registration; and (3) the very real likelihood that this legislation would have been adopted regardless of the association's opposition. Subsequently, the association was able to effect a reduction in the annual registration fee in both pre-filed bills from $50 to $10 and ultimately one of these bills (SB 2058) was passed by both Houses of the legislature and signed into law by the governor.

MPAC and Candidate Support Activities—Membership. Membership in MPAC and AMPAC has continued to grow by leaps and bounds during the year. At the end of February 1975, our MPAC had 1,053 members as compared to 629 at this same time last year. By the same token, we had 951 members who also belonged to AMPAC through February as compared to only 587 at the same time during 1974. Last month we were notified by AMPAC that MPAC was the first state PAC to break its all-time high membership total at so early a date.

Candidate Support. The MPAC Board will meet throughout the summer to discuss several key legislative races where the incumbents have a poor record on health issues. Efforts will be made to designate candidates in these areas who are responsive to medicine and we will attempt to encourage one or more members in these areas to organize a candi-

date support committee to assist the selected candidate in his campaign. In May or June we hope to schedule a candidate support workshop which the AMPAC staff has agreed to put on for the purpose of training those physicians and their wives who have indicated their desire to organize a candidate support committee. In addition, the Board will also consider any request for support from a group of physicians in an area that wishes to assist the campaign efforts of any legislative incumbent or challenger. We also plan to work with a Jackson public relations firm on developing a candidate support "package" which will be available for a pre-determined price. The "package" might consist of such support items as posters, billboards, newspaper ads, and TV or radio spots.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered the report of the Board of Trustees concerning the association's legislative program. We concur in the report. We note with interest and urge the continued efforts of our members to take an active part in legislative activities. It was repeatedly stressed to your reference committee during consideration of this report and others dealing with health legislation that we must have a local, "grass-roots" approach to our legislators. Our staff can and does keep us well informed on legislative matters but action in this regard only comes through our contact with our local legislators. We commend the Board, our Council on Legislation, and our Mississippi Political Action Committee for their efforts reflected in *Supplemental Report A*. We also wish to especially note and commend our association's legislative counsel, William F. Roberts, for his work in this regard.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT B OF THE BOARD OF TRUSTEES

Scheduling of MSMA Annual Sessions. Section 2, Article V of the Constitution states that ". . . the time and place for holding the annual session shall be fixed by the House of Delegates . . ." and Section 1, Chapter II of the By-Laws states that ". . . the session shall . . . be held prior to the annual session of the American Medical Association. . . ."

Because of scheduling difficulties on a year-to-year basis, the House of Delegates approved a four-year advance schedule in 1967. Additionally, in 1970, the House of Delegates directed that future annual sessions be scheduled to avoid conflict with Mother's Day and with municipal elections. The former occurs on the second Sunday in May; primaries for the latter occur on the second Tuesday in May every four years.

Dates and Sites for the Annual Sessions. At the 106th Annual Session in 1974 the House of Delegates directed that the association meet in Jackson in 1976 and thereafter meet on the gulf coast in odd numbered years and in Jackson in even numbered years. Based on this, the present annual session schedule is as follows:

Annual Session	*Place and Date*
108th	Jackson, May 3-6, 1976
109th	Biloxi, May 2-5, 1977
110th	Jackson, May 1-4, 1978

Recommendation. Following requirements of the MSMA Constitution and By-Laws concerning scheduling of annual sessions of the association and policies of the House of Delegates, the Board of Trustees recommends that the 111th Annual Session of the association be conducted in Biloxi, May 7-10, 1979.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received the report of the Board of Trustees concerning the scheduling of annual meetings of the association. The present annual session schedule as previously approved by the House is as follows:

Annual Session	*Place and Date*
108th	Jackson, May 3-6, 1976
109th	Biloxi, May 2-5, 1977
110th	Jackson, May 1-4, 1978

The Board, following requirements of the MSMA Constitution and By-Laws concerning scheduling of annual sessions and policies of the House of Delegates in this regard, recommends that the 111th Annual Session be conducted May 7-10, 1979, in Biloxi. We concur in this recommendation and note that the exact hotel sites for the annual sessions willl be negotiated by the Board of Trustees based on recommendations of the Council on Scientific Assembly.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT C OF THE BOARD OF TRUSTEES

Background. In the 1973 Legislative Session, the Missouri Legislature enacted a law authorizing the licensure of chiropractors in Mississippi. This li-

censure act, to "regulate chiropractors," was to be administered by five chiropractors and one M.D. As understood by the association and others, the act specifically prohibited the use of the title "Dr." by chiropractors as well as their use of advertising. In addition, the definition of the practice of chiropractic as contained in the law limited their scope of practice to adjustment of the spine thus eliminating their use of other modalities or modes of treatment.

Following the Board of Chiropractic Examiner's organization, they promulgated regulations authorizing the use of the title "Dr." in addition to sanctioning certain limited types of advertising in the form of patient mailings. These regulations were adopted despite the objections of the physician member of the chiropractic board, who, following their publication, requested an opinion from the attorney general regarding the legality of these regulations. Subsequently, the attorney general refused to rule on the issue of whether these regulations were commensurate with the terms of the law. Additionally, it had also come to the attention of the association staff and membership that chiropractors were using certain "modalities" in treatment and not limiting their practice to adjustment or manipulation of the spine.

Consideration by Council on Legislation. After receiving numerous complaints from the membership and others regarding chiropractic use of the title "Dr.," advertising, and "modalities," the Council on Legislation at its November 1973 meeting considered the introduction of legislation to clarify certain provisions of the chiropractic licensure act. The council concluded that legislation amending the chiropractic licensure act should not be sought since its passage might be unsuccessful and even if the amendments were adopted their enforcement might still be questionable in view of the past actions of the chiropractic board. In lieu of seeking additional legislation, the council recommended to the MSMA Board of Trustees that:

1. The association employ legal counsel to appear before the Board of Chiropractic Examiners to request their reconsideration of the regulations regarding advertising and use of the title "Dr." and enforcement of the definition of chiropractic practice in limiting the scope of such practice solely to adjustment of the spine; and

2. If the request for reconsideration of these regulations failed, that the Board of Trustees consider authorizing counsel to bring suit against the chiropractic board for failure to implement the provisions of the chiropractic licensure act.

In December 1973, the Board of Trustees adopted the recommendations of the Council on Legislation and shortly thereafter legal counsel was retained to carry out the council's recommendation.

Meeting with Board of Chiropractic Examiners. In October 1974, legal counsel together with MSMA staff met with the executive committee of the chiropractic board and their attorney to discuss their issuance of these regulations and the use of modalities by chiropractors. Following that meeting it was apparent that the chiropractic board is firm in their belief that the law does not prohibit their use of the title "Dr." or the employment of "modalities" in treatment regardless of our objections to the contrary. It should also be noted that the meeting revealed the fact that the chiropractic board did express an interest in eliminating the more flagrant types of advertising by chiropractors while concisely sanctioning other less obvious methods.

After this meeting, the association's counsel recommended that it would be futile to continue further administrative efforts in persuading the chiropractic board to carry out the provisions of the 1973 licensure law, and that in view of the seriousness of this matter and the association's concern for the general health and protection of the public, that legal action be instituted to prevent any further violations of the chiropractic practice act.

Recommendations of Board. The Board of Trustees considered these recommendations at its December 1974 and March 1975 meetings and discussed them at length with counsel. Of particular interest to the Board was the fact that under the terms of the law, the association could not bring suit against the chiropractic board to prohibit their failure to carry out the provision of the chiropractic licensure act. Rather, if suit were brought it would have to be filed against one or more individual chiropractors to enjoin their violations of the chiropractic licensing statute. But such a suit would serve two purposes; namely, establishing a legal case "precedent" that would interpret once and for all the provisions of the chiropractic licensure act, and once this precedent was established, it would serve to persuade the chiropractic board to rescind their regulations sanctioning such violations.

Your Board of Trustees believes if we in the medical profession are truly concerned about and intent upon protecting the public from unqualified practitioners, then we must act decisively and firmly

to prevent blatant disregard of the laws which are designed to protect the public health. The Board therefore recommends that:

1. The association authorize counsel to initiate the necessary legal proceedings to terminate violations of the chiropractic licensure act by Mississippi chiropractors; and
2. That each member of the association contribute $10 to fund these legal proceedings.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

This report reflects the concern of all physicians that in the interest of the public's health unlicensed persons not be allowed to practice medicine. Specifically, the report recommends that the association initiate necessary legal action to terminate apparent practices of chiropractors in the state which violate provisions of the chiropractic licensing act and result in the practice of medicine without a license. Said legal proceedings would be financed by the membership. Your reference committee concurs in the report.

Dr. J. K. Williams of Pascagoula moved an amendment to the report to have its intent also include optometrists, seconded by Dr. Samuel B. Johnson of Jackson. The amendment was defeated and after further discussion the report of the reference committee was adopted.

SUPPLEMENTAL REPORT D OF THE BOARD OF TRUSTEES

Background. Last July your association was requested to cooperate with station WAPT-TV, the ABC affiliate in Jackson, in programing a weekly series to discuss medical subjects of broad public interest. The program was to be called "House Call" and consist of a moderator and a physician participant who after a few introductory remarks about the medical subject under discussion, would answer telephone calls from the viewing public.

After much work by many people and particularly Mr. Craig Potter of station WAPT-TV, and Dr. J. Dan Mitchell, association coordinator for the program, "House Call" had its debut on July 22, 1974. I am happy to report that the program's success has exceeded all expectations. Through April 1975, some 40 physicians had appeared on the program. Not one scheduled physician participant has missed his "House Call." Recently, "House Call" was rated the number one public service program in Mississippi by the American Research Bureau, a national television rating authority.

Recommendation. Your Board of Trustees recommends that this House of Delegates present a special "appreciation award" to station WAPT-TV in Jackson during the final session on Thursday, May 8. The award will be in recognition of that station's outstanding community service and promotion of a better public understanding of the practice of medicine in presenting the weekly television series "House Call."

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered this report of the Board which recommends that a special "appreciation award" be presented to station WAPT-TV, Jackson in recognition of that station's outstanding community service in presenting the weekly television series "House Call."

We concur in this recommendation and especially commend the work of the program coordinator for this program, Dr. J. Dan Mitchell of Jackson.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT E OF THE BOARD OF TRUSTEES

1. *Background.* The Board of Trustees has recently appointed an *ad hoc* Committee on Professional Liability Insurance to consider the status of the physicians' professional liability insurance market in Mississippi. Further, the committee is to recommend future courses of action the association might take to ameliorate the growing crisis facing the medical profession and the public because of the increased costs and decline of the physicians' professional liability insurance market.

2. *The St. Paul Company's Professional Liability Insurance Program.* Since 1961 the association has endorsed the St. Paul Company's Professional Liability Insurance Program. The program has provided a stable, low-cost market and at this time some 1,300 physicians in Mississippi participate in the program. Today the St. Paul Company is only writing new business for physicians' professional liability insurance in Mississippi and seven other of its program endorsed states.

Earlier this year the St. Paul Company announced a major change in its underwriting policies. As an "alternative to completely withdrawing from the market," the company announced that beginning in 1975 it would only write physicians' professional liability insurance on a "claims made" basis. The "claims made" policy differs from the company's

present "occurrence type" policy in that it covers only claims reported during the policy period. The "claims made" policy contains a provision providing the policyholder a right to purchase a "reporting endorsement" when he or she retires or coverage is otherwise discontinued. The "reporting endorsement" provides coverage for claims not reported during the period of the "claims made" policy.

The Committee on Professional Liability Insurance and the Board of Trustees have met with representatives of the St. Paul Company to discuss the company's new "claims made" policy. Representatives of the St. Paul Company have been invited to appear at the meeting of the Reference Committee on Reports of Officers and Board of Trustees this afternoon to further discuss the "claims made" policy and to answer questions you may have in this regard.

3. *The Market for Physicians' Professional Liability Insurance.* The market for physicians' professional liability insurance is declining and in a number of states at this time it is almost non-existent even at higher premiums. In some states "joint underwriting associations" and "self-insured programs" have been proposed because of the lack of a viable and competitive market for physicians' professional liability insurance. The Committee on Professional Liability Insurance and the Board of Trustees plan to study these proposals.

4. *Changes in the Malpractice Legal System.* Admittedly, the new "claims made" policy of the St. Paul Company will not solve the basic causes of the medical malpractice crisis. They will have to be accompanied by changes in the present legal system for resolving medical malpractice claims. The Committee on Professional Liability Insurance and the Board of Trustees have carefully reviewed suggested changes in the malpractice legal system to improve that system's present procedures for providing relief for medical claims. We are indebted to many of the association's component societies and members for guidance and suggestions they have given us in this connection. After careful review and consideration of Mississippi's malpractice legal system, we propose the following:

a. *Burden of Proof.* Require that a plaintiff have the burden of proving by affirmative evidence the failure to follow the recognized accepted standard of practice in the community and that such evidence be established by competent medical testimony. In addition, no person shall be competent to testify unless he is licensed to practice the profession practiced by the defendant in the state or contiguous bordering states during the year preceding the date of the commencement of testimony.

b. *Statute of Limitations.* Require that any claim for malpractice must be filed within two years following the alleged act or injury or one year after discovery of such injury but in no case shall any claim be filed after six years from the occurrence of such injury.

c. *Informed Consent.* Provide that the issue of informed consent is a medical question which should be determined by the acceptable standards of custom and practice established in the state or contiguous bordering states.

d. *Arbitration.* Provide for the settlement of any malpractice dispute through arbitration in lieu of bringing suit.

e. *Malpractice Screening Committee.* Requires that any claim for malpractice be first submitted to a review committee composed of two physicians and two attorneys and that the decision of the committee regarding the merits of such claim may be introduced into evidence by either party in a subsequent suit.

f. *Establish Reasonable Guidelines on Contingency Fees.* Requests the Mississippi Bar Association to join with the Mississippi State Medical Association in appointing a joint committee to establish guidelines on contingency fees whose membership will consist of two attorneys and one consumer appointed by the bar association and two physicians and one consumer appointed by the medical association.

Finally, not by way of legal change but by education, we propose that the association join with all interested parties in establishing programs for physicians on the cause and prevention of malpractice claims.

The Board wishes to further acknowledge the work of the Committee on Professional Liability Insurance on this report. The committee's members are:

Martin B. Harthcock, Jr., M.D., Jackson, Chairman
Thomas R. Singley, M.D., Pascagoula
Thomas J. Marland, M.D., Jackson
John G. Caden, Jr., M.D., Jackson
Frank W. Bowen, M.D., Carthage
Louie F. Wilkins, Jr., M.D., Brookhaven

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered this report and no doubt it received more comment and discussion than any matter before the committee. We are grateful to the members and guests who met with the reference committee on this matter. In addition to *Supplemental Report E* there were a number of resolutions before the committee concerning this matter noted below:

Supplemental Report E states:

"The Committee on Professional Liability Insurance and the Board of Trustees have carefully reviewed suggested changes in the malpractice legal system to improve that system's present procedures for providing relief for medical claims. We are indebted to many of the association's component societies and members for guidance and suggestions they have given us in this connection. After careful review and consideration of Mississippi's malpractice legal system, we propose the following:

a. *Burden of Proof*—Require that a plaintiff have the burden of proving by affirmative evidence the failure to follow the recognized accepted standard of practice in the community and that such evidence be established by competent medical testimony. In addition, no person shall be competent to testify unless he is licensed to practice the profession practiced by the defendant in the state or contiguous bordering states during the year preceding the date of the commencement of testimony.

b. *Statute of Limitations*—Require that any claim for malpractice must be filed within two years following the alleged act or injury or one year after discovery of such injury but in no case shall any claim be filed after six years from the occurrence of such injury.

c. *Informed Consent*—Provide that the issue of informed consent is a medical question which should be determined by the acceptable standards of custom and practice established in the state or contiguous bordering states.

d. *Arbitration*—Provide for the settlement of any malpractice dispute through arbitration in lieu of bringing suit.

e. *Malpractice Screening Committee*—Require that any claim for malpractice be first submitted to a review committee composed of two physicians and two attorneys and that the decision of the committee regarding the merits of such claim may be introduced into evidence by either party in a subsequent suit.

f. *Establish Reasonable Guidelines on Contingency Fees*—Request the Mississippi Bar Association to join with the Mississippi State Medical Association in appointing a joint committee to establish guidelines on contingency fees whose membership will consist of two attorneys and one consumer appointed by the bar association and two physicians and one consumer appointed by the medical association.

Finally, not by way of legal change, but by education, we propose that the association join with all interested parties in establishing programs for physicians on the cause and prevention of malpractice claims."

In discussion before your committee concerning the above changes in our present malpractice legal system recommended in *Supplemental Report E,* there were additional recommendations in this regard. We have been assured that the Committee on Professional Liability Insurance and the Board of Trustees have access to all sources of information on this subject and will consider every possible alternative in formulating effective legislation for introduction in the 1976 regular session of the Mississippi legislature. We have also received assurance from the business and insurance communities of their interest in this matter and desire to work with the association in this regard. We are grateful for this.

Your reference committee notes these assurances and concurs with the recommendations contained in *Supplemental Report E.*

During discussion of Item a. *Burden of Proof,* Dr. Richard C. Miller of Jackson moved that the words "is licensed to practice" be deleted and "has practiced" be substituted. The motion was seconded by Dr. W. Moncure Dabney of Crystal Springs and adopted.

During discussion of Item b. *Statute of Limitations,* Dr. Sidney O. Graves of Natchez moved that the wording be changed to two years for adults and two years from age four for children "after occurrence" rather than "discovery."

The amendment was seconded by Dr. Gerald A. Gable of Hattiesburg and adopted.

The report of the reference committee was adopted as amended.

REPORT OF THE SECRETARY-TREASURER

Dr. James P. Spell: Duties and Responsibilities. As an elected general officer of the association, your

Secretary-Treasurer is charged with such duties as ordinarily devolve upon the secretary of a corporation by law, custom, and usage. Additionally, he is the constitutional designee to serve as chairman of the Council on Scientific Assembly and member *ex officio* of all councils and committees.

Membership. Total membership as of Dec. 31, 1974, was as follows:

1,410 paid Active members
47 Emeritus members
45 members exempt from dues other than Emeritus

This is a total of 1,502 MSMA for 1974. I think that it's interesting to note that as of Dec. 31, 1973, we had 1,357 paid Active members. There has been a significant increase in membership. As of April 14, 1975, our current year's membership was:

1,348 paid Active members
46 Emeritus members
48 members exempt from dues other than Emeritus

This is a total of 1,442 for 1975. Additional payments of dues have been made since preparation of these data. Final date for payment of MSMA 1975 dues is April 1.

Fiscal Reporting. In accordance with usual practice, your Secretary-Treasurer submits a condensed statement of your association's financial condition. The Council on Budget and Finance prepared the budget for 1975 which was approved by the Board of Trustees, and a copy is attached to this report.

Constitutional Duties. Your Secretary-Treasurer, as an *ex officio* member of councils and committees, meets with various official bodies of the association and sits with the Board of Trustees as a general officer. Activities related to service as chairman of the Council on Scientific Assembly are reported separately.

MISSISSIPPI STATE MEDICAL ASSOCIATION
Condensed Statement of Financial Condition
Dec. 31, 1974

ASSETS

Current Assets		
General Fund		
Cash on Deposit	$119,980.19	
Accounts Receivable—JOURNAL	3,563.18	
Accounts Receivable CHAMPUS	15,006.47	
Other Current Receivables	14,253.53	
Inventory—Insurance Forms	2,891.18	
Prepaid Expenses	2,601.66	
Total Current Assets		$158,296.21
Fixed Assets		
Building, Office Furniture and Equipment, Less Depreciation	$184,271.50	
Land (at cost)	14,242.28	
Total Fixed Assets		$198,513.88
Deferred Expenses		
Deferred CHAMPUS Expenses	$ 11,059.95	
Total Deferred Expenses		$ 11,059.95
Other Assets		
Refundable Deposits	$ 25.00	$ 25.00
Total Assets		$367,895.04

LIABILITIES AND NET WORTH

Current Liabilities		
Accrued Expenses	$ 12,418.61	
Accounts Payable:		
Local Society Dues	7,517.00	
Auxiliary Dues	1,170.00	
Accounts Payable—AMA Dues and ERF	25,596.00	
Accounts Payable—Dues AMPAC and MPAC	3,340.00	
Accounts Payable—U. S. Government—CHAMPUS	702.62	
Mortgage Payable Current Portion	7,120.00	
Accrued Taxes	2,447.44	
Other Current Liabilities	98.46	
Total Current Liabilities		$ 60,410.13
Long Term Liabilities		
Mortgage Payable—Deposit Guaranty National Bank		$ 55,180.00
Deferred Income		$121,784.67
Net Worth		
Unappropriated Net Worth, Dec. 31, 1973	$135,302.90	
Net Income (Loss) for Year Ended Dec. 31, 1974	(4,782.66)	
Net Worth, Dec. 31, 1974		$130,520.24
Total Liabilities and Net Worth		$367,895.04

MISSISSIPPI STATE MEDICAL ASSOCIATION
1975 BUDGET

Projected Income		
Dues Sources		
MSMA		$ 181,250.00
AMA		140,000.00
AMA Commissions		1,300.00
Directory and Supplement		$ 7,500.00
Journal		
Advertising	$ 22,000.00	
Other (Rebate, Paid Subs.)	1,500.00	
Reprints	1,000.00	$ 24,500.00
107th Annual Session		
Exhibit Sales	$ 9,450.00	
Scientific Grants	1,000.00	
Social Occasions	700.00	$ 11,150.00
Other Income		
Interest Earned	$ 6,000.00	
Data Processing	1,000.00	
Sundry Income	1,000.00	
CHAMPUS Administration	160,000.00	
EMCRO Grant	150,000.00	$ 318,000.00

Total	$ 683,700.00
Less AMA Transmittals	-140,000.00
Less EMCRO Grant	-150,000.00
Less CHAMPUS Administration	-160,000.00
Net Projected Income	$ 233,700.00

MISSISSIPPI STATE MEDICAL ASSOCIATION
1975 BUDGET

Projected Expenses	
107th Annual Session	$ 11,645.00
Board of Trustees	3,000.00
Councils and Committees	1,000.00
Committees—CHAMPUS	1,000.00
Building Maintenance	3,500.00
Contract Labor	300.00
Dues and Subscriptions	850.00
Equipment Rentals	3,500.00
Office Equipment Maintenance	700.00
Office Equipment Maintenance—CHAMPUS	460.00
Office Equipment Maintenance—EMCRO	210.00
Grounds Maintenance	1,000.00
Group Insurance	3,500.00
Group Insurance—CHAMPUS	4,242.00
Group Insurance—EMCRO	1,470.00
Other Insurance	2,500.00
Interest	4,984.00
Other Office Expenses	350.00
Postage	9,000.00
Postage—CHAMPUS	11,500.00
Postage—EMCRO	1,600.00
Professional Services	2,800.00
Professional Services—CHAMPUS	1,000.00
Professional Services—EMCRO	14,000.00
Pension Plan	3,600.00
Pension Plan—CHAMPUS	1,000.00
Data Processing Services	9,600.00
Data Processing Services—CHAMPUS	9,000.00
Data Processing Services—EMCRO	34,000.00
Salaries	101,472.00
Salaries—CHAMPUS	107,199.00
Salaries—EMCRO	49,060.00
Printing and Supplies	13,500.00
Printing and Supplies—CHAMPUS	8,300.00
Printing and Supplies—EMCRO	12,525.00
Property Taxes	6,000.00
Payroll Taxes	5,300.00
Payroll Taxes—CHAMPUS	7,200.00
Payroll Taxes—EMCRO	3,529.00
Telephone and Telegraph	6,000.00
Telephone and Telegraph—CHAMPUS	5,000.00
Telephone and Telegraph—EMCRO	2,600.00
Travel	8,000.00
Travel—CHAMPUS	1,000.00
Travel—EMCRO	5,000.00
Utilities	8,400.00
Journal Production	30,000.00
Journal—Other	2,500.00
Journal Reprints	1,100.00
EMCU	2,600.00
Total	$ 527,596.00
Less OCHAMPUS Expenses	-156,901.00
	$ 370,695.00
Less EMCRO Grant	-123,994.00
Net Projected Expenses	$ 246,701.00

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered the report of our secretary-treasurer, Dr. James P. Spell. We note that association membership is at an all time high and that we had our greatest increase in membership this past year. We commend Dr. Spell and our other officers for the continued growth in association membership and for their management of the association's fiscal affairs. Your reference committee recommends adoption of this report.

The report of the reference committee was adopted.

REPORT OF THE EXECUTIVE SECRETARY

Mr. Charles L. Mathews, Executive Secretary: The office of executive secretary staffs the activities of the association under the direction and supervision of the Board of Trustees. This report presents an overview of your administrative staff and ongoing association programs and activities.

Programs and Activities. The association continued and expanded its programs and services for the membership during the 1974-75 association year. The uniform insurance claim form, the MPAC Bulletin, and an expanded accreditation program for continuing medical education are but a few of the programs and services added this past year. At the same time, continuing programs such as your *Journal MSMA*, government relations, and CHAMPUS have been strengthened thanks in large part to your continued willingness to provide the resources for a competent staff to work on your behalf.

Also during the year and certainly not as an aside, the Mississippi Professional Standards Review Organization was staffed and made operational. I wish to publicly acknowledge and commend the staff for the support they have given, both directly and indirectly, in reaching the point of my standing here today and telling you that the Mississippi PSRO is staffed and operational.

Staff. There are at present 28 employees at your MSMA office. Nine of these employees have duties with association programs such as the *Journal,* membership, and internal management. All nine positions have been in effect since 1970. All other staff positions are with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and programs to be phased into the Mississippi Foundation for Medical Care. Your MSMA office building is at capacity with present staff and programs and at this time the Mississippi Foundation for Medical

Care is leasing 6,000 square feet of office space in Jackson.

In closing let me express the staff's appreciation for your continued confidence in us "to get the job done."

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received the report of our executive secretary. We wish to note and commend our staff for their good work.

The report of the reference committee was adopted.

AUXILIARY OFFICERS

The speaker presented Mesdames Dan Reikes of Hattiesburg, 1974-75 president of the Woman's Auxiliary to the Mississippi State Medical Association, and J. Edward Hill of Hollandale, 1975-76 president, who addressed the House of Delegates. New president-elect of the women's group is Mrs. W. A. Brown of Mathiston.

1975 MSMA-ROBINS AWARD

President Davis presented the 1975 Mississippi State Medical Association-Robins Award to Dr. Thomas M. Davis of Jackson for outstanding community service by a physician. Dr. Davis, a family practitioner, was cited for his work as Hinds County coroner, in the Red Cross and with civilian disaster control. Mr. Willard Duval from the A. H. Robins Company of Richmond, Va., assisted Dr. Davis in the presentation of the award, an engraved plaque.

RESOLUTION NO. 1, IN MEMORIAM

Dr. James P. Spell:

WHEREAS, There are absent from among our numbers 20 members who have been called by Divine Providence since the 106th Annual Session; and

WHEREAS, Although we are grieved by the passing of these beloved colleagues and friends, we are inspired by their lives of service and professional attainment; and

WHEREAS, This expression of our grief, deep affection, and respect should be recorded permanently among official records of the Mississippi State Medical Association, now therefore, be it

Resolved, That this House of Delegates does mourn the passing of the following esteemed colleagues:

Maxwell D. Berman, Jackson, April 12, 1975
William O. Biggs, Osyka, February 8, 1975
Arthur E. Brown, Columbus, July 29, 1974
Rome G. Dabbs, Shannon, July 1, 1974
Lloyd E. Deddens, Jackson, April 25, 1974
Boni J. DeLaureal, Pass Christian, November 29, 1974
Nollie C. Felts, Sr., Hattiesburg, November 1, 1974
William H. Goodloe, Jr., Jackson, December 21, 1974
Peyton R. Greaves, Jackson, May 28, 1974
Pearl E. Hackman, Gulfport, February 24, 1975
Daniel L. Hollis, Biloxi, April 19, 1975
A. C. Hunter, Columbus, November 28, 1974
Lee White Johnson, Columbia, February 17, 1975
William A. King, Rosedale, February 11, 1975
John Robert Laird, Newton, January 5, 1975
Otto A. Schmid, Jackson, May 3, 1974
Frank O. Schmidt, Ocean Springs, February 25, 1975
Daniel E. Staton, Columbus, December 29, 1974
Jack A. Stokes, Pontotoc, June 1, 1974
Robert E. Wheaton, Meridian, September 21, 1974

ACTION OF THE HOUSE OF DELEGATES

Without objection, Resolution No. 1 was acted upon without referral and adopted by the House of Delegates with all present standing in silent tribute.

RESOLUTION NO. 2, REALIGNMENT OF ASSOCIATION DISTRICTS

Dr. Arthur A. Derrick:

WHEREAS, Gross inequity existed and still exists as to association district representation on the Board of Trustees; and

WHEREAS, Any realignment plan that disrupts component societies will never be satisfactory to all concerned; now therefore be it

Resolved, That the following clause of Section 8, Chapter VIII, By-Laws of Mississippi State Medical Association be stricken ". . . provided that all counties in a component society shall be in one association district . . . ;" and be it further

Resolved, That the districts be defined as follows:

District 1: Boliver, Coahoma, Humphreys, Issaquena, Leflore, Quitman, Sharkey, Sunflower, Tallahatchie, Tunica, Washington, and Yazoo.

District 2: Alcorn, Benton, Calhoun, DeSoto, Itawamba, Lafayette, Lee, Marshall, Panola, Pontotoc, Prentiss, Tate, Tippah, Tishomingo, Union, and Yalobusha.

District 3: Chickasaw, Clay, Kemper, Lauder-

dale, Lowndes, Monroe, Neshoba, Newton, Noxubee, Oktibbeha, and Winston.

District 4: Attala, Carroll, Choctaw, Claiborne, Grenada, Holmes, Leake, Madison, Montgomery, Rankin, Scott, Simpson, Smith, Warren, and Webster.

Districts 5 and 6: Hinds.

District 7: Clarke, Forrest, George, Greene, Jasper, Jones, Perry, Stone, and Wayne.

District 8: Adams, Amite, Copiah, Covington, Franklin, Jeff Davis, Jefferson, Lamar, Lawrence, Lincoln, Marion, Pearl River, Pike, Walthall, and Wilkinson.

District 9: Hancock, Harrison, and Jackson.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Your reference committee considered Resolution No. 2 introduced by Dr. Arthur A. Derrick and Dr. C. D. Taylor. This resolution provides:

Resolved, That the following clause of Section 8, Chapter VIII, By-Laws of Mississippi State Medical Association be stricken ". . . provided that all counties in a component society shall be in one association district . . . ;" and be it further

Resolved, That the districts be defined as follows:

District 1: Bolivar, Coahoma, Humphreys, Issaquena, Leflore, Quitman, Sharkey, Sunflower, Tallahatchie, Tunica, Washington and Yazoo.

District 2: Alcorn, Benton, Calhoun, DeSoto, Itawamba, Lafayette, Lee, Marshall, Panola, Pontotoc, Prentiss, Tate, Tippah, Tishomingo, Union and Yalobusha.

District 3: Chickasaw, Clay, Kemper, Lauderdale, Lowndes, Monroe, Neshoba, Newton, Noxubee, Oktibbeha and Winston.

District 4: Attala, Carroll, Choctaw, Claiborne, Grenada, Holmes, Leake, Madison, Montgomery, Rankin, Scott, Simpson, Smith, Warren and Webster.

Districts 5 and 6: Hinds.

District 7: Clarke, Forrest, George, Greene, Jasper, Jones, Perry, Stone and Wayne.

District 8: Adams, Amite, Copiah, Covington, Franklin, Jeff Davis, Jefferson, Lamar, Lawrence, Lincoln, Marion, Pearl River, Pike, Walthall and Wilkinson.

District 9: Hancock, Harrison and Jackson.

Your reference committee was again impressed with the strong feelings among many members of the association that something should be done to provide for a more equitable distribution of members per trustee in our association districts. The desire to do something about realigning our districts was evident from testimony presented to the committee at its meeting. The primary question about which most of the debate centered at the committee's meeting dealt with *how* the districts should be realigned in order to provide for an equitable distribution. It is evident that this House and our membership in general is opposed to the adoption of any realignment plan which disrupts any of the association's 18 component societies. It is also apparent that eliminating our MSMA constitution provision requiring component society lines to conform to district lines would create more problems than it would solve.

In considering these problems your reference committee attempted to develop a realignment plan that would not disrupt any of our component societies or in any way rescind the House's action on Monday of authorizing an additional trustee from District 5. The plan which is attached accomplishes both of the committee's objectives (Exhibit 1). *This realignment of our association districts would not disrupt or break-up any component society nor would it affect the election of an additional trustee from District 5.* The committee's proposed plan provides for eight association districts with a range of from 117-214 members per trustee as compared with the existing ratio of 34-480. Your committee feels that this is the best plan possible to meet the objectives of this House and our association. The committee would also like to point out that if adopted, this realignment plan would have to lie on the table for a year pending final approval at the 108th Annual Session in 1976.

Your reference committee, therefore, recommends that Resolution No. 2 be not adopted and in lieu thereof we recommend the following realignment plan be distributed to each component society prior to final action at the 108th Annual Session:

District 1: Attala, Bolivar, Carroll, Choctaw, Coahoma, Grenada, Holmes, Humphreys, Leflore, Montgomery, Quitman, Sunflower, Tallahatchie Tunica, Washington, Webster.

District 2: Alcorn, Benton, Calhoun, Chickasaw, DeSoto, Itawamba, Lafayette, Lee, Marshall, Monroe, Panola, Pontotoc, Prentiss, Tate, Tippah, Tishomingo, Union, Yalobusha.

District 3: Clarke, Clay, Kemper, Lauderdale, Lowndes, Neshoba, Newton, Noxubee, Oktibbeha, Winston.

Districts 4 and 5: Hinds, Madison, Leake, Rankin, Scott, Simpson. Smith, Yazoo.

District 6: Adams, Amite, Claiborne, Copiah,

Franklin, Issaquena, Jefferson, Lawrence, Lincoln, Pike, Sharkey, Walthall, Warren, Wilkinson.

District 7: Covington, Forrest, George, Greene, Jefferson Davis, Jasper, Jones, Lamar, Marion, Pearl River, Perry, Wayne.

District 8: Hancock, Harrison, Jackson, Stone.

The report of the reference committee was adopted.

RESOLUTION NO. 3, PROFESSIONAL LIABILITY INSURANCE CRISIS

Dr. David M. Owen:

WHEREAS, The professional liability insurance market is in a crisis that effects both physicians and their patients; and

WHEREAS, This crisis has reached such proportions in some parts of the country that physicians are unable to obtain liability insurance except at a cost that greatly increases the cost of providing medical care to their patients; and

WHEREAS, It is imperative that our Mississippi State Medical Association work with all interested parties in seeking solutions to the professional liability insurance crisis; therefore be it

Resolved, That the Mississippi State Medical Association take immediate action directed at providing Mississippi physicians with continued malpractice insurance at a reasonable cost; and be it further

Resolved, That the Mississippi State Medical Association consider all methods to solve the professional liability insurance crisis to include seeking a reduction in the present statute of limitations for filing malpractice claims.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered this resolution which recommends that the association consider all methods to solve the professional liability insurance crisis to include seeking a reduction in the present statute of limitations for filing malpractice claims. We concur in this recommendation.

The report of the reference committee was adopted.

RESOLUTION NO. 4, EQUALIZE PAYMENT FOR PHYSICIANS' SERVICES UNDER MEDICARE

Dr. Donald Rayner:

WHEREAS, The Medicare Program as provided for in Section 1842 of the Social Security Act states that "no charge (i.e., physicians' professional fee) may be determined to be reasonable . . . if it exceeds the prevailing charge level that . . . would cover 75 per cent of the customary charges made for similar services in the same locality . . . ;" and

WHEREAS, Application of Section 1842 of the Social Security Act by the Bureau of Health Insurance of the Social Security Administration has resulted in unequal payments for comparable physicians' services between Mississippi and other states; and

WHEREAS, The equal distribution of health care services appears to be of prime concern to the Congress and federal government on the one hand but yet on the other hand the Medicare Program discriminates against physicians locating in Mississippi by paying less for professional services than paid for comparable services in other parts of the country; and

WHEREAS, Medicare beneficiaries in Mississippi pay the same amount for coverage of professional services as Medicare beneficiaries in other parts of the country and expect comparable professional services; now therefore be it

Resolved, That the Mississippi State Medical Association goes on record as supporting the equalization of payment of professional fees under the Medicare Program; and be it further

Resolved, That copies of this resolution be furnished to the Bureau of Health Insurance of the Social Security Administration and to the entire Mississippi congressional delegation; and be it further

Resolved, That copies of this resolution also be furnished to the Mississippi Foundation for Medical Care, Inc.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee considered Resolution No. 4 introduced by Dr. Donald Rayner, Delegate from Coast Counties Medical Society. This resolution states:

"*Resolved,* That the Mississippi State Medical Association goes on record as supporting the equalization of payment of professional fees under the Medicare Program; and be it further

"*Resolved,* That copies of this resolution be furnished to the Bureau of Health Insurance of the Social Security Administration and to the entire Mississippi congressional delegation; and be it further

"*Resolved,* That copies of this resolution also be furnished to the Mississippi Foundation for Medical Care, Inc."

Your reference committee is highly cognizant of the difficult problems which have been created for physicians in Mississippi as a result of Medicare's

existing payment structure, and therefore recommends the adoption of Resolution No. 4.

In discussion, Dr. Joseph B. Rogers stated that he was in favor of the thought behind this motion but wanted to point out that the AMA had fought hard not to have a national fee schedule. Dr. Rogers then moved that the word "adjustment" be substituted for the word "equalization." The motion was seconded by Dr. Lamar Arrington of Meridian and adopted.

The report of the reference committee was adopted as amended.

RESOLUTION NO. 5, MEDICAL PUBLIC RELATIONS PROGRAM

Dr. J. Dan Mitchell:

WHEREAS, The medical profession has an obligation to inform the public about noteworthy advances in medical science; and

WHEREAS, It is in the medical profession's interest to make the public aware of all scientific activities to improve the public's health; and

WHEREAS, The medical profession and public will benefit by a better medical "public relations" program; now therefore be it

Resolved, That the Mississippi State Medical Association furnish guidance and urge each of its component societies to establish meaningful contact with the local press to implement a medical public relations program.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee considered Resolution No. 5, introduced by Dr. Dan Mitchell, council member, Mississippi State Medical Association. This resolution states:

"*Resolved,* That the Mississippi State Medical Association furnish guidance and urge each of its component societies to establish meaningful contact with the local press to implement a medical public relations program."

Your reference committee firmly believes that every physician, every component society and the state medical association should be concerned about and make every effort to maintain the best possible image of the medical profession. We, therefore, recommend the adoption of Resolution No. 5.

The report of the reference committee was adopted.

RESOLUTION NO. 6, ESTABLISH SECTION ON RADIOLOGY

Dr. W. Lamar Weems:

WHEREAS, The American Medical Association has for some time recognized a section on radiology within its organization; and

WHEREAS, The Mississippi Radiological Society is a recognized chapter of the American College of Radiology and therefore all its members are diplomats of the American Board of Radiology; and

WHEREAS, The Mississippi Radiological Society has for some time contributed the much respected radiologic seminar published in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION; and

WHEREAS, The Mississippi Radiological Society has for some time held its May meeting on the Sunday immediately preceding the Mississippi State Medical Association Annual Session at the site of the MSMA session; and

WHEREAS, The radiologists of the state of Mississippi as represented by the Mississippi Radiological Society desire to be recognized and accepted as a section in the scientific assembly; now therefore be it

Resolved, That the Mississippi State Medical Association recognize the specialty of radiology as a section within the association under requirements of Chapter IV, MSMA By-Laws.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Your reference committee considered Resolution No. 6 introduced by Dr. Lamar Weems, delegate from Hinds County. This resolution provides:

"*Resolved,* That the Mississippi State Medical Association recognize the specialty of radiology as a section within the association under requirements of Chapter IV, MSMA By-laws."

Your reference committee is in accord with this proposed amendment and recommends the adoption of Resolution No. 6.

The report of the reference committee was adopted.

RESOLUTION NO. 7, INCLUSION OF COVERAGE OF PSYCHIATRIC DISORDERS IN HEALTH INSURANCE POLICIES

Dr. Ellis M. Moffitt:

WHEREAS, A significant number of people with health insurance in Mississippi do not have coverage for either hospitalization or physician care for psychiatric disorders; and

WHEREAS, Health insurance coverage for psychiatric disorders is an insurable risk; and

WHEREAS, The occurrence of psychiatric disorders poses an economic burden on patients which can be disastrous; now therefore be it

Resolved, That the Mississippi State Medical Association support enactment of legislation requiring inclusion of coverage of psychiatric disorders in health insurance policies sold in Mississippi.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered this resolution which would have the association support legislation requiring inclusion of coverage of psychiatric disorders in health insurance policies sold in Mississippi. We concur in this recommendation.

The report of the reference committee was adopted.

RESOLUTION NO. 8, STATUTE OF LIMITATIONS

Dr. T. T. Lewis:

WHEREAS, The state of Mississippi has an unusually long statute of limitations (six years); and

WHEREAS, The surrounding states of Arkansas, Alabama, Louisiana, and Tennessee have statutes of limitations of one to two years; now therefore be it

Resolved, That the Mississippi State Medical Association immediately explore possible methods to induce legislative action to relieve this inequity.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered this resolution which recommends that the association seek changes in the state's present statute of limitations for filing malpractice claims. We concur in this recommendation.

The report of the reference committee was adopted.

RESOLUTION NO. 9, PROFESSIONAL LIABILITY INSURANCE PROBLEM

Dr. Robert Ray McGee:

WHEREAS, Professional liability insurance is becoming increasingly expensive and in some areas impossible to obtain; and

WHEREAS, This problem is soon likely to affect Mississippi as it has other areas, it is imperative that our Mississippi State Medical Association work with all interested parties including the Mississippi State Bar Association in seeking solutions to the problem; and

WHEREAS, Other states have initiated programs to replace current malpractice procedures with arbitration methods similar to workmen's compensation; therefore be it

Resolved, That the Mississippi State Medical Association consider all methods to solve the professional liability insurance problems to include urging legislative action to provide some method of arbitration to replace the present system.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered this resolution which recommends that the association consider all methods to solve the professional liability insurance problems to include urging legislative action to provide some methods of arbitration to replace the present system. We concur in this recommendation.

The report of the reference committee was adopted.

RESOLUTION NO. 10, MEETINGS WITH STATE LAWMAKERS

Dr. Sidney O. Graves:

WHEREAS, We are living in an era requiring close contact with our chosen representatives; and

WHEREAS, This undertaking is too large a job for our very capable legislative committee; now therefore be it

Resolved, That each component medical society of the Mississippi State Medical Association plan to execute a meeting with their respective state legislators in December 1975. This meeting should be separate from the scheduled meeting of said societies and the entire membership of the society should be encouraged to attend the meeting so that the representatives will realize that our goals are indeed the goals of the entire membership.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

This resolution reaffirms past policy of the association urging component societies to conduct formal meetings with their local legislators preferably prior to each session of the Mississippi legislature. We concur in this recommendation.

The report of the reference committee was adopted.

RESOLUTION NO. 11, CONTROLS ON MEDICAL MALPRACTICE CLAIMS

Dr. Sidney O. Graves:

WHEREAS, Medical liability insurance coverage is being eliminated in many states and curtailed in our own; and

WHEREAS, Physicians cannot begin or remain in practice in areas where protection from million dollar plus judgements is not available; and

WHEREAS, Industry will not locate in areas of marginal medical practice; now therefore be it

Resolved, That the Mississippi State Medical Association expend every effort to have the Mississippi Legislature enact a bill embodying the following controls on medical malpractice claims:

1. Create malpractice screening panels to determine validity of malpractice claims, such panels to be composed of one physician chosen by the plaintiff, one physician chosen by the defendant, one physician chosen by the other two physicians on the panel, and a lawyer agreed to by both the plaintiff and defendant or chosen by lot. The lawyer shall be a nonvoting member of the panel and serve as chairman. Conclusions of the panel are admissible in court.

2. Establish statute of limitation for malpractice claims at two years from occurrence for adults and two years after age four for children.

3. Eliminate "ad damnum" clause.

4. Limit expert testimony to board certified specialists practicing within the state and within the special field for which they are furnishing testimony.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered this resolution which recommends specific changes in Mississippi's present legal system for handling malpractice claims. Your reference committee believes that the recommendations contained in the resolution have merit but that they should be considered along with similar recommendations before the association's Committee on Professional Liability Insurance. Recommendation No. 3 in the resolution, i.e., eliminate "ad damnum" clause, was particularly supported by those in attendance at the reference committee meeting. We recommend that Resolution No. 11 be not adopted and instead be referred to the Committee on Professional Liability Insurance.

The report of the reference committee was adopted.

RESOLUTION NO. 12, REAFFIRMATION OF POSITION RELATIVE TO USE OF DRUGS BY OPTOMETRISTS

Dr. Ellis M. Moffitt:

WHEREAS, Contrary to the public welfare there is continued pressure on members of the Mississippi legislature to enact legislation authorizing use of pharmaceutical agents by optometrists for diagnostic purposes; and

WHEREAS, The eye cannot be treated as a separate entity but must be considered as a part of the body as a whole with devastating complications including blindness and death sometimes resulting from topical application of drugs to the eye; and

WHEREAS, Optometrists are not prepared to administer the emergency medical attention which would be necessary to protect the patient in such situations; and

WHEREAS, The placing of pharmaceutical agents in the hands of non-medical personnel through the legislative process rather than through education and training threatens the established medical delivery system including all medical specialties; now therefore be it

Resolved, That the Mississippi State Medical Association reaffirm its strong and unyielding opposition to all legislation which has as its objective the use of drugs by optometrists; and be it further

Resolved, That all local societies and individual members of MSMA be apprised of this alarming situation and urged to actively support MSMA's position.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered this resolution which affirms the association's strong and unyielding opposition to all legislation which has as its objective the use of drugs by optometrists and urges that all members be apprised of this alarming situation and urged to actively support MSMA's position. We concur in this recommendation.

The report of the reference committee was adopted.

RESOLUTION NO. 13, NOMINATION OF RICHARD E. PALMER TO PRESIDENT-ELECT OF THE AMERICAN MEDICAL ASSOCIATION

Dr. David R. Steckler:

WHEREAS, Richard E. Palmer, a pathologist from Alexandria, Virginia, has been nominated to be the president-elect of the AMA; and

WHEREAS, Dr. Palmer has been chairman of the AMA's Board of Trustees since October 1973 and previously had been vice-chairman and is serving his second term on the AMA's Board of Trustees; and

WHEREAS, Dr. Palmer has been president of the American Society of Clinical Pathologists, and the

Medical Society of Virginia and is currently a member of the American Board of Pathology's Executive Committee; and

WHEREAS, Dr. Palmer was chairman of the American Board of Commissioners of the Joint Commission on Accreditation of Hospitals and has served as commissioner representing the AMA since 1966; now therefore be it

Resolved, That the Mississippi State Medical Association go on record as unanimously in favor of Dr. Palmer being nominated to the chair of president-elect of the American Medical Association.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered this resolution which would have the association go on record in favor of Dr. Richard E. Palmer of Virginia being nominated to the chair of president-elect of the American Medical Association. During discussion of the resolution we heard favorable comments about Dr. Palmer and no doubt he would make a fine president-elect. We believe, however, that our delegates to the AMA will consider and vote for officers of the AMA after careful consideration of all announced candidates. We therefore recommend that this resolution be not adopted and instead be brought to the attention of our delegates to the AMA for their consideration.

The report of the reference committee was adopted.

PRESENTATION OF SCIENTIFIC EXHIBIT AWARDS

Dr. James P. Spell, chairman of the Council on Scientific Assembly, announced the awards for outstanding scientific exhibits. "Abdominal and Obstetrical Ultrasonography" by Drs. Kenneth G. Carter and James M. Packer of Jackson received the first prize Aesculapius Award, an engraved walnut plaque, for best exhibit by a member(s) of the association. Second place in the member category went to "Pediatric Malignancies" by Drs. Richard C. Miller, Jeanette Pullen and Patricia C. Moynihan of the University Medical Center. "The Transphenoidal Approach to Pituitary Tumors" by Dr. James T. Robertson of Memphis received the association's Scientific Achievement Award, a sculptured bronze medallion, in recognition of the best presentation by a nonmember.

SPECIAL AWARDS

Dr. Edgar T. Beddingfield of Wilson, North Carolina, a member of the American Medical Political Action Committee Board, was present to give an award to the Mississippi Political Action Committee on behalf of AMPAC. Dr. L. Stacy Davidson of Cleveland, MPAC chairman, accepted the award, an engraved plaque, which was given for the category ratio of members to potential.

The Board of Trustees in Supplemental Report D asked that a special award of appreciation be presented to WAPT-TV for production of the weekly public service program, "House Call." Dr. J. Dan Mitchell of Jackson, association coordinator for the program, presented an engraved plaque to Mr. Craig Potter, program moderator, during the concluding session of the House of Delegates.

AMA-ERF

President Davis presented the yearly contribution to the American Medical Association-Education and Research Fund by physicians, their families and Ole Miss Medical Alumni to Vice Chancellor Dr. Norman Nelson. Dr. Frank Bowen of Carthage, medical alumni association president, was also present when the check for $12,211.35 was given to the medical center.

OFFICIAL ATTENDANCE

The official attendance was announced as being 794 to include 376 members, 53 M.D. guests, 15 interns, residents and medical students, 17 non-M.D. guests, 124 exhibitors, 197 Auxiliary members and 12 staff.

REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

Conduct of Business. Your reference committee commends the speaker and vice-speaker for the outstanding manner in which they have conducted business before this House of Delegates. We believe that all members will wish to associate themselves in this expression of appreciation.

Resolution. The reference committee desires to offer the following resolution for consideration by the House of Delegates:

WHEREAS, The 107th Annual Session of the Mississippi State Medical Association has been conducted at Biloxi, Mississippi, during the period May 5-8, 1975; and

WHEREAS, The annual session has been most profitable and enjoyable for all who have been in attendance; now therefore be it

Resolved, That expressions of deep appreciation are made to the officers, trustees and Council on Scientific Assembly for the stimulating and worthwhile scientific programs; to the management of the Sheraton-Biloxi, and to other participating hotels and motels; to the press, radio and television for coverage of our activities; to the gracious ladies of the auxiliary who always contribute so substantially to our meetings; to the technical exhibitors and their professional service representatives; to our scientific exhibitors who have contributed to our learning and instruction; to our distinguished guests, particularly Dr. Malcolm C. Todd of Long Beach, California, president of the American Medical Association; and to all who have shared in the responsibilities of planning, organizing and conducting this great annual session.

Your reference committee recommends adoption of this resolution.

The report of the reference committee was adopted.

REPORT OF THE ELECTION OF OFFICERS

President-elect: Lyne S. Gamble, Greenville.

Vice Presidents: J. Edward Hill, Hollandale; William B. Hopson, Jr., Vicksburg; and J. P. Culpepper, III, Hattiesburg.

Speaker, House of Delegates: C. D. Taylor, Jr., Pass Christian (1978).

Vice Speaker, House of Delegates: R. F. Triplett, Jackson (1978).

Delegate to AMA: G. Swink Hicks, Natchez (1977).

Alternate Delegate to AMA: Stanley Hill, Corinth (1977).

Associate Editor: Myron W. Lockey, Jackson (1977).

Board of Trustees: Max Pharr, Jackson, District 5; Gerald P. Gable, Hattiesburg, District 7; Sidney O. Graves, Natchez, District 8; and Paul H. Moore, Pascagoula, District 9 (1978).

Council on Budget and Finance: J. Dan Mitchell, Jackson, and David L. Clippinger, Gulfport (1978).

Council on Constitution and By-Laws: Louis C. Lehmann, Natchez (1978).

Judicial Council: William B. Hunt, Grenada; Samuel B. Johnson, Jackson; and Martin Flynt, Meridian (1978).

Council on Legislation: Everett Crawford, Tylertown; Charles R. Jenkins, Laurel; and Ray H. Stewart, Gulfport (1978).

Council on Medical Education: Whitman B. Johnson, Clarksdale (1978).

Council on Medical Service: Donald R. Ellis, Clarksdale; John R. Lovelace, Batesville; and Thomas N. Braddock, West Point (1978).

CLOSING CEREMONIES

There being no further business, the speaker returned the gavel to President Davis. The Oath of Office was administered to Dr. Jack A. Atkinson, the president-elect, by Dr. James O. Gilmore, chairman of the Board of Trustees, after which Dr. Atkinson addressed the House of Delegates.

Mrs. James Grant Thompson of Jackson presented the Thompson Memorial Past President's Pin to Dr. Davis.

The House of Delegates was adjourned *sine die* at 11:41 o'clock in the morning, May 8, 1975.

Constitution and By-Laws of the Mississippi State Medical Association

CONSTITUTION

Preamble

That more may live longer in the richness and comfort of health; that pain, suffering, and disease may be eradicated to the extent made possible by scientific medical knowledge; that the standards of the medical profession may be maintained on the highest plane of honor, we dedicate ourselves as physicians through this Association. Among us, membership is a privilege, earned by professional qualification, personal honor, and selfless service; it is not a right vested superficially nor by statutory licensure. Truth shall be our quest; diligence, our staff; and service, our purpose.

Article I
NAME OF THE ASSOCIATION

The name and title of this Association shall be the Mississippi State Medical Association.

Article II
PURPOSE OF ORGANIZATION

The purpose of this Association shall be to federate and into one compact organization the entire medical profession of the state of Mississippi and to unite with similar associations in other states to form the American Medical Association, with a view toward the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws, to the promotion of friendly intercourse among the physicians and to guarding and fostering of their opinion in regard to the great problems of medicine, so that the profession shall become more honorable and capable within itself, and more useful to the public in the prevention and care of disease, and in the prolonging of and adding comfort to life.

The purpose of this Association shall be to promote scientific medical research and practice and it shall be a nonprofit organization.

Article III
COMPONENT SOCIETIES

Component Societies shall consist of those societies which hold charters from the Association.

Article IV
MEMBERSHIP

Section 1. Members of the Mississippi State Medical Association. Members shall be active, associate, emeritus, or honorary, according to requirements and provisions of the By-Laws. There may also be invited guests. Membership other than associate and honorary shall be construed as active in connection with the rights and privileges accruing therefrom.

Section 2. Guests. Any physician not a resident of the state may become a guest during any annual session upon invitation of a member of the Association, and shall be accorded the privilege of participating in all the scientific work of that session.

Article V
SESSIONS AND MEETINGS

Section 1. The Association shall hold an annual session during which there shall be held daily not less than two general meetings, which shall be open to all registered members and guests.

Section 2. The time and place for holding the annual session shall be fixed by the House of Delegates, but in emergencies, the Board of Trustees shall have the power to fix, or change, either the time or the place, or both of the annual session.

Article VI
GENERAL OFFICERS

Section 1. The general officers of this Association shall be President, President-elect, three Vice-Presidents, one from each Supreme Court District, Secretary-Treasurer, Speaker, Vice Speaker, and Editor.

Section 2. The President, President-elect, and Vice-Presidents shall hold terms of one year. The Secretary-Treasurer, Speaker, Vice Speaker and Editor shall be elected for terms of three years.

Section 3. The officers of this Association shall be elected by the House of Delegates on the last day of the annual session following the adjournment of the general meeting, but no person shall be elected to any such office who has failed to attend one of the past two or current annual sessions and who has not been a member for the past two years.

Section 4. In addition to these general officers, there shall be an Executive Secretary who need not be a physician or member of the Association. He shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. His compensation and expenses for duties performed shall be fixed by the Board of Trustees and confirmed by the House of Delegates.

Article VII
EXECUTIVE OR CENTRAL OFFICES

The Executive Secretary shall maintain in the city of Jackson suitable offices for the discharge of his duties and for conducting the administrative affairs of the Association.

Article VIII
HOUSE OF DELEGATES

The House of Delegates shall be the legislative, business, and policy-making body of the Association and shall consist of (1) delegates selected by the component societies under authorized apportionment, (2) the general officers of the Association, (3) all past presidents, provided they still be members in good standing of the Association, (4) members of the Board of Trustees and Councils, and (5) elected committees, Delegates and Alternate Delegates to the American Medical Association, members of the State Board of Health, and members of the Board of Trustees of Mental Institutions, all of whom must be members of this Association.

Article IX
BOARD OF TRUSTEES

The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates and shall perform such duties as are prescribed by law governing directors of corporations and in the By-Laws of the Association. The Board shall consist of 12 members, one from each of the nine Association Districts, except Association District V which is authorized two members, elected for terms of three years each and the President and Immediate Past President. A Trustee shall not serve more

than two consecutive terms and no member shall be eligible for re-election to the Board of Trustees after serving two consecutive terms until that individual has been off the Board for at least six years.

Article X
FUNDS AND EXPENSES

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by annual dues, per capita assessments upon the membership, and by voluntary contributions. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, publications, and for any other purpose approved by the House of Delegates.

Article XI
THE SEAL

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII
AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been sent officially to each component society at least two months before the session at which final action is taken.

BY-LAWS

Chapter I
MEMBERSHIP

Section 1. Eligibility. Each component society of the Mississippi State Medical Association shall judge the qualifications of candidates for election to membership therein, which shall be restricted to those persons who hold the degree of Doctor of Medicine from an appropriately accredited source as defined by the American Medical Association, or in lieu thereof, a foreign degree in medicine which is an acceptable equivalent to the Board of Trustees and shall be a citizen of the United States. All candidates for any degree of membership other than associate or honorary must be legally licensed to practice medicine in Mississippi. Persons who obtained this degree prior to January 1, 1917, need not comply with this requirement but must be licensed to practice medicine in Mississippi or, if offering to practice in Mississippi must be eligible for license by reciprocity and be a member in good standing of a constituent (state) association of the American Medical Association. Membership in a component society, evidenced by the payment of dues for the current year, shall be a prerequisite to membership in the Association, except that a physician upon his initial application for membership in a component society of the Association shall be required to undergo a waiting period of ninety (90) consecutive days from the date he begins the practice of medicine in the geographical area of the component society before he may be elected to membership in the component society. No physician shall be eligible for membership who has been convicted of or who has plead guilty to either a felony or a violation of a state or federal narcotics law. The duly certified court record shall be *prima facie* evidence of pleas and convictions and cause automatic revocation of membership. No physician shall be eligible for election to or continuation of membership who does not possess a currently effective federal narcotics stamp, provided, however, that physicians in full time government service who need no registration to use, prescribe, and dispense narcotic drugs and those who, by reason of type of practice, employment, inactivity, or retirement, neither prescribe nor dispense narcotics and who for this reason alone have not applied for registration shall be exempt from this requirement.

Section 2(a). Good Standing. Only those members in good standing shall be entitled to the rights and privileges of membership. A physician not in good standing may not be elected to office nor exercise the privilege of voting or attending any session of this Association, scientific or otherwise. The name of a physician upon the properly certified roster of a component society which has paid its annual assessment shall be *prima facie* evidence of his right to register at the annual session of the Mississippi State Medical Association. No member shall participate in any of the proceedings of the annual session until he is duly registered. No delegate or other member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this session. (b) Change of State Residence. In the event that a member moves from the State, his membership shall continue until, and lapse at the end of, the current fiscal year, but this provision shall not operate to prevent a physician who moves from the state continuing his membership by payment of all dues and assessments to the state Association). (3) Obligations of Membership. When the Executive Secretary of the Mississippi State Medical Association is officially informed by the secretary of a component society that a physician is not in good standing in the component society, he shall remove the name of the physician from the rolls of the Association. A member shall hold his membership through the component society in the jurisdiction of which he practices, provided that a physician living on or near a county line may hold membership in the society most convenient for him to attend. If the society in which he chooses to secure membership does not exercise jurisdiction over the area of his residence, then permission must be obtained from the jurisdiction society to facilitate his affiliation with the extra-jurisdiction society.

Section 3. Degrees of Membership. Members of the Mississippi State Medical Association shall be divided into the following classifications: Active, emeritus, and associate. (a) Active Membership. Active members shall include all eligible members of component societies in good standing, providing that all dues and assessments in this Association as may be hereinafter prescribed have been received by the Association. (b) Emeritus Members. Any member of the Mississippi State Medical Association who has been an active member for any ten consecutive years and shall have permanently retired from the practice of medicine shall be eligible for election to emeritus membership. Election to emeritus membership for reasons of retirement in the case of permanent and total disability shall merit special consideration but shall be subject to ruling by the Board of Trustees. Election to emeritus membership shall be based on the recommendation of the component society and the approval of the Board of Trustees. (c) Associate Membership. Any commissioned medical officer in the United States Army, United States Air Force, United States Navy, or United States Public Health Service, or any physician in the employ of the Veterans Administration, not licensed to practice in the State of Mississippi, stationed in Mississippi, members of medical faculties of medical schools in Mississippi, approved by the American Medical Association, who are not licensed to practice in the state, any hospital intern, or any hospital resident in Mississippi, may, on election to associate membership by the component society in whose jurisdiction the physician resides become an associate of the Mississippi State Medical Association. Associate members shall not vote or hold office. (d) Honorary Membership. A layman who has rendered meritorious service may on approval and nomination by the Judicial Council be elected to honorary membership by majority vote of the House of Delegates. Honorary members shall not vote or hold office.

Section 4. Dues and Assessments. A per capita assessment determined by the House of Delegates shall constitute the dues of the Association, which assessment shall be collected from all active members by the respective secretaries of the

component societies, provided that new members shall be accepted on payment of three-fourths of annual dues after May 1 and one-half of annual dues after September 1. Each active member shall pay the prescribed dues to the officer designated by the component society for transmittal to the Executive Secretary of the Association. Dues shall include a subscription to the official publication of the Association. (a) Members Excused From Payment. The Board of Trustees may, by majority vote, excuse a member from payment of dues because of undue hardship or similar circumstances warranting special consideration provided that the component society shall have excused in full the payment of dues for periods exceeding one year. Such circumstances shall be interpreted to include extended illness and temporary disability. Members who shall have attained age 70 and who have been active members of the Association for any 10 consecutive years may, upon request, be exempt from dues for life effective January 1 after the 70th birthday, and such exemption shall continue so long as the member continues in good standing in his component medical society. (b) Emeritus Members. Physicians who have been elected emeritus members shall not be required to pay dues in the Association. (c) Payment of Dues and Delinquency. Dues of the Association are due and payable on December 31 of the year prior to that for which dues are prescribed. Failure to pay dues by April 1 of the year for which due shall result in forfeiture of membership privileges and the removal of the member's name from the rolls of the Association. A five dollar ($5.00) reinstatement cost shall be assessed against any member who is delinquent by reason of non-payment of dues after April 1 of the year for which dues are payable. A member in good standing who is called to active duty with the Armed Forces of the United States other than in the regular component shall be carried as an active member without payment of dues until such time as he is released from military service.

Section 5. American Medical Association. Members of this Association desiring to be members of the American Medical Association may pay the dues or apply when eligible, for legal exemption from the dues of the American Medical Association. Those desiring to do so may pay their dues to the Executive Secretary whose duty shall be to transmit them to the American Medical Association and to obtain proper credits and receipts therefor.[1]

Section 6. Revocation of Emeritus or Associate Membership. Any emeritus or associate membership may be revoked by two-thirds vote of the House of Delegates when, in the opinion of the House of Delegates, the conduct or actions of the emeritus or associate member violates any of the principles of the code of ethics or whose conduct or actions are not becoming to the honor conferred.

Chapter II
ANNUAL AND SPECIAL SESSIONS

Section 1. Time and Place. An annual session shall be held as required by Article V, Section 1, the Constitution of the Mississippi State Medical Association, which session shall in any event be held prior to the annual session of the American Medical Association. The place of the state session shall be fixed in accordance with Article V, Section 2, the Constitution of the Mississippi State Medical Association.

Section 2. Special Session. A special session of the Association or of the House of Delegates may be called by the President, with the approval of the Board of Trustees. The Board of Trustees is empowered to call a special session by majority concurrence.

Section 3. Inviting an Annual Session. A component society desiring the Association and House of Delegates to meet in annual session in a city within its jurisdiction may submit an invitation in writing or verbally through its representative to the House of Delegates at the annual session concerned with the selection of the site for the next regular scheduled meeting. The dates and site of the annual session selected may be changed by majority vote of the Board of Trustees in an emergency requiring such a change.

Section 4. Registration Privileges. Only the following shall be permitted to register at any session:

(a) Active members
(b) Emeritus members
(c) Associate members
(d) Honorary members
(e) Invited guests
(f) Medical students of American Medical Association approved medical schools who are certified to the Executive Secretary of the Association by their respective deans.
(g) Interns and residents who are graduates of American Medical Association approved medical schools and who are connected with an approved hospital and who are certified to the Executive Secretary of the Association by their respective hospital superintendents in event they are not associate members of the Association.
(h) Commissioned medical officers of the United States Armed Forces who are on active duty and who if not associate members are certified to the Executive Secretary by their Post or Base Surgeons or Commanding Officers.

Section 5. Indebtedness. A member shall not be permitted to register unless all current indebtedness to both the Association and component of proper jurisdiction has been paid.

Section 6. Admittance. Admittance to any meeting of the House of Delegates, any scientific section, or any of the various exhibits at an annual session of the Association shall be limited to members in good standing, duly registered and invited guests, members in good standing of the Woman's Auxiliary to the Mississippi State Medical Association, duly accredited and registered members of the Press, and accredited technical and scientific exhibitors.

Chapter III
GENERAL MEETING

Section 1. Participation. The general meeting shall include all registered members and guests, who shall have equal rights to participate in the proceedings and discussions, but no member shall vote on any question coming before a section of the general meeting except those who have registered as members of such sections. Each section of the general meeting shall be presided over by its chairman. The address of the President and the Distinguished Service Oration shall be delivered before the general meeting at such time and place as may be arranged.

Section 2. Order. The order of exercise, papers, and discussions as set forth in the official program shall be followed from day to day until it has been completed. But no section shall be allowed to place more than five papers on its program, nor more than two invited guest essayists (out-of-state or non-member). When a section program is not completed within the time assigned, it shall not be allowed to continue into that assigned to another section.

Section 3. Time Restrictions. No address or paper before the Association, except those of the President and Orator, shall occupy more than twenty minutes in its delivery, except that guests may be allowed thirty minutes; and in formal discussion no one shall speak more than five minutes; and in informal discussion no one shall speak more than three minutes and not more than one time.

Section 4. Essayists. With the exception of the invited guests, the essayists must be members of the Association. No name shall appear more than once on the printed program to discuss a paper before the regular scientific sections un-

[1] Became effective Jan. 1, 1972.

less such person qualifies for membership as provided in these By-Laws.

Section 5. Papers. All papers read before the Association shall be its property. Each paper must be read by its author, and must be deposited with the Secretary when read.

Section 6. Failure to Read Paper. No author listed on the program who fails to read a paper at the session may be allowed a place on the program of the next annual session, but if the author, being unable to attend, shows his good intent by forwarding his paper to the Secretary before the annual session, he shall not suffer the penalty.

Chapter IV
SCIENTIFIC SECTIONS

Section 1. Designation of Sections. The scientific sections of the Association shall be as follows: (a) Section on Medicine, (b) Section on Surgery, (c) Section on Preventive Medicine, (d) Section on Eye, Ear, Nose and Throat, (e) Section on Pediatrics, (f) Section on Obstetrics and Gynecology, (g) Section on General Practice, (h) Section on Anesthesiology, and (i) Section on Radiology.

Section 2. Section Officers. Each scientific section of the Association shall, as the last order of business during its regular meeting, elect a chairman who shall serve for a period of one year. A majority of votes cast shall be necessary to elect. Additionally, each section shall elect a secretary whose term of office shall be for a period of three years and so arranged that secretaries shall be elected by their respective sections at the same annual meeting as follows: (1) Sections on General Practice, Anesthesiology, and EENT, (2) Sections on Obstetrics and Gynecology and Preventive Medicine, and (3) Sections on Pediatrics, Surgery, and Medicine.

Section 3. Program. The Council on Scientific Assembly shall place any paper in its proper section. The Council shall so arrange the program that no one section shall be given precedence over others two years in succession.

Chapter V
HOUSE OF DELEGATES

Section 1. Apportionment and Representation. Each organized county shall be entitled to representation in all regular and special sessions of the House of Delegates, one delegate and one alternate for each fifty members in the county and one delegate and one alternate for each fraction thereof, but each organized county holding a charter from this organization having made its annual report and paid its assessments, as provided in this Constitution and By-Laws shall be entitled to at least one delegate and alternate, said alternate delegates to act only in the absence of the delegate or delegates from the respective counties. No county in a component society shall be without representation in the House of Delegates; each shall be entitled to one delegate and one alternate without regard to total membership. No alternate may be seated at any regular or special session of the House of Delegates unless the delegates elected from that county shall be absent or otherwise unable to participate in the proceedings. In the event that neither the delegate nor the alternate is able to attend the regular or special session to which they have been accredited, then any *bona fide* resident of the county may, if properly registered, qualify himself as a delegate. No representative of the component society shall be seated in the House of Delegates until all his dues, assessments, and obligations to the component society have been paid. Delegates and alternates shall be elected by their respective component societies for terms of not less than two years and shall assume office on the first day of the annual session following their elections; they shall be *bona fide* residents of the counties which they represent. Their names shall be reported to the Central Office of the Association not later than thirty days prior to the first day of the annual session. Representatives of component societies shall be seated in the House of Delegates only following their proper registration of credentials from the component societies they represent.

Section 2. Meetings and Attendance. The House of Delegates shall meet annually on the first day of the annual session of the Association. The House of Delegates shall meet for the conclusion of business on the last day of the annual session immediately following the adjournment of the last general or scientific session, provided that these requirements shall not operate to prevent such other meetings of the House of Delegates during the annual session as the House itself may order or the President or Speaker may deem necessary, but no such meetings may be called at times which would conflict with the scheduled general or scientific session. Duly registered members and guests may attend all meetings of the House of Delegates provided that they occupy a distinctly separate section of the meeting hall or auditorium and further provided that they shall not be permitted to participate in any phase of the meeting of the House of Delegates except on invitation of that body. By majority vote, the House of Delegates may enter into executive session, during which time only qualified delegates and officers of the Association may remain in attendance.

Section 3. Quorum. A three-fifths majority of registered and duly seated delegates of this Association shall constitute a quorum.

Section 4. Order of Business. The order of business shall be conducted at the pleasure of the House of Delegates, provided it shall not be in conflict with either these By-Laws or the Constitution. Meetings shall be conducted according to *Sturgis Standard Code of Parliamentary Procedure*, and within the bounds of courtesy and this Constitution and By-Laws. Generally, the order of business shall be:

(1) Adoption of the Transactions of the previous meeting.
(2) Reports of Boards, Councils and Committees.
(3) Reports of Presidential Committees.
(4) Special Orders.
(5) Unfinished Business.
(6) New Business.

Section 5. Memorials and Resolutions. No memorials or resolutions shall at any time be issued in the name of the Mississippi State Medical Association by any officer or member thereof until such memorial or resolution has been approved and adopted by the House of Delegates or Board of Trustees.

Section 6. Duties and Responsibilities. It shall, through its officers and otherwise, give diligent attention to foster the scientific work and spirit of the Association, and shall constantly study and strive to make each annual session a stepping stone to future ones of higher interest. It shall consider and advise the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto. It shall make careful inquiry into the condition of the profession of each county in the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in the counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county in the state has been brought under medical society influence. It shall encourage postgraduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the component societies. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, the term of office to begin on January 1 of the year following that of the elections and continuing for two suc-

cessive years. It shall, upon recommendation of the Board of Trustees, provide and issue charters to counties organized to conform to the spirit of the Constitution and By-Laws.

Section 7. Reference Committees. Business brought before the House of Delegates will normally be referred by the Speaker for hearing, debate, and recommendation to a reference committee. Sufficient reference committees shall be appointed by the President to expedite and assist in the deliberations of the House of Delegates. Such committees shall consist of not less than three nor more than five members, all of whom shall be members of the House of Delegates, who shall serve only during the regular or special session for which appointed. Any member of the Association shall have the privilege of appearing before a reference committee on any issue being considered. Additionally, reference committees may permit the appearance of any individual who, in the opinion of the committee, can assist its deliberations.

Chapter VI
ELECTION OF OFFICERS

Section 1. Ballot. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect.

Section 2. Nominations. The House of Delegates on the first day of the annual session shall select a Committee on Nominations consisting of nine members of the House of Delegates, one from each Association District. It shall be the duty of this committee to consult with the members of the Association and to hold one or more meetings at which the best interests of the Association and of the profession of the state for the ensuing year shall be carefully considered. The committee shall nominate to the House of Delegates three names for each general officer vacancy and two names for all other offices. No two candidates for President-elect may be named from the same county. Nominations for appointment to membership on the Mississippi State Board of Health shall be made by the House of Delegates in accordance with Section 7024, Mississippi Code of 1942, provided that six names shall be submitted, three of whom shall be elected and their names submitted to the Governor as nominees from each district, provided no member shall be nominated who has served two consecutive terms. The House of Delegates shall nominate five physicians when vacancies occur on the Board of Trustees of Mental Institutions which nominations shall be submitted to the Governor in accordance with law.

Section 3. Report of Nominations. The House of Delegates shall receive the report of the Committee on Nominations and elect officers, Trustees, and Council members on the last day of the annual session.

Section 4. Nominations from the Floor. Nothing in this Chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 5. Executive Secretary. The Board of Trustees shall select and appoint an Executive Secretary as elsewhere prescribed in the Constitution and By-Laws of the Association.

Chapter VII
DUTIES OF OFFICERS

Section 1. President. The President shall have general supervision over all meetings of the various bodies of the Association, shall appoint all committees not otherwise provided for, shall deliver an annual address at such time and place as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall fill by appointment all vacancies occurring during his tenure of office among the general officers and on the Board of Trustees and Councils and shall be empowered to appoint such committees on an *ad hoc* basis as may be desired or required to conduct the affairs of the Association. He shall be an *ex officio* member of all Councils and committees. He shall be the real and acknowledged head, as well as the personal representative, of the medical profession of the State of Mississippi during his term of office, and insofar as practicable, shall visit by appointment the various sections of the state and the component societies of the Mississippi State Medical Association and assist the Trustees in their tasks of aiding and strengthening the component societies and in making their work more useful.

Section 2. President-elect. The President-elect shall be in charge of the work of organization, including membership, under the direction of the President, and shall exercise these duties and advise with the Vice Presidents and with the Board of Trustees in this phase of their activity. He shall be an *ex officio* member of all Councils and committees. He shall succeed to the presidency upon the event of the death, resignation, or removal from office of the President. This automatic succession shall not operate to disqualify him from serving the next regular term of office unless he has served more than six months as President.

Section 3. Vice Presidents. The Vice Presidents shall assist the President in the discharge of his duties. They shall further assist the President-elect in the work of organization, including membership in their respective areas, and in promoting the welfare of the Association and the profession of the state.

Section 4. Speaker. A Speaker shall be elected for a term of three years. This officer may be chosen from the membership of the Association, irrespective of any affiliation with the House. The Speaker shall familiarize himself with the rules and usages of parliamentary procedure, with the laws of the House. On him shall devote the duty of bringing before the House through the various officers and chairmen all reports and other matters that are to receive its attention. He shall preside at all meetings of the House and perform the duties usual to the position and office of chairman except in the appointment of committees, which shall be the privilege of the President.

Section 5. Vice Speaker. A Vice Speaker shall be elected for a term of three years to run concurrently with that of the Speaker. The Vice Speaker shall assist the Speaker in all duties prescribed in these By-Laws.

Section 6. Secretary-Treasurer. The Secretary-Treasurer shall be elected for a term of three years. He shall perform such duties ordinarily devolving on a secretary of a corporation by law, custom, or parliamentary usage and shall enjoy the rights and perform such other duties as may be granted or imposed in the Constitution and these By-Laws. He may delegate such duties as are herein described to the Executive Secretary who shall be responsible therefor. He shall be an *ex officio* member of all Councils and committees.

Section 7. Executive Secretary. The Executive Secretary shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. He need not be a member of the Association nor a physician. He shall maintain a Central Office for the Association and shall be responsible for the management and proper functioning of the Central Office to the President of the Association and the Board of Trustees. He shall attend all sessions and meetings of the Association, the House of Delegates, the Board of Trustees, and shall serve at all times to perform such other duties as may be deemed beneficial to the Association by the President and Board of Trustees. He shall assist elected officers, Councils, committees, and Trustees in the performance of their duties. Under instructions from the President, he shall conduct a comprehensive program of public education and all such other activities as may disclose favorably to the public at large the aims, objectives, and goals of service of the medical profession in Mississippi. He shall, when requested, place himself in position to assist any of the component societies of the Association and he shall attend meetings of the component societies when invited by officers thereof. He

shall be made custodian of records, books and papers belonging to the Association and he shall keep account of and promptly place under the supervision of the Secretary-Treasurer such funds as may be delivered into his hands in the name of the Association. He shall give bond at the expense of the Association in such amount as may be required. He shall provide for the registration of the members and delegates at the annual session and cooperate in preparing for and arranging all functions of the Association, including the annual session. He shall procure an exact transcript of all proceedings of the House of Delegates. He shall maintain a register of all legal practitioners in Mississippi and he shall maintain detailed and exact records of the membership with regard to component societies, the Mississippi State Medical Association, and the American Medical Association. He shall issue evidence of membership to each physician who pays the annual assessment and is accepted in the Mississippi State Medical Association. He shall maintain close and complete liaison with the American Medical Association and shall keep the component societies informed of activities, programs, and mandates of both the state Association and the American Medical Association. He shall publish from the Central Office such memoranda, bulletins, and miscellaneous publications as may be directed by the President, the Board of Trustees, and the House of Delegates. He shall conduct the official correspondence of the Association as he may be directed. He shall employ such assistants as may be required, upon authorization of the Board of Trustees. He shall supply each component society with blank forms to be used in connection with membership and reports. He shall maintain records of monies paid by the component societies for assessments and dues. He shall prepare and publish under the direction of the President and Board of Trustees such programs as may be necessary for official functions of the Association. He shall be reimbursed for expenses incurred in the performance of his duties, separately and in addition to his regular compensation.

Chapter VIII
BOARD OF TRUSTEES

Section 1. Board of Trustees. The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates. It shall consist of 12 members, one from each Association District, except Association District V which is authorized two members, whose terms of office shall be three years. A Trustee shall not serve more than two consecutive terms. No member shall be eligible for re-election to the Board of Trustees after serving two consecutive terms until that individual has been off the Board for at least six years. The President and Immediate Past President of the Association shall also serve on the Board of Trustees. During vacation, the Board of Trustees shall exercise the powers conferred upon the House of Delegates by the Constitution and these By-Laws, provided that in the exercise of these powers thus conferred, the Board of Trustees shall neither consider nor act to contravene any action, mandate, or policy of the House of Delegates which may still be in effect.

Section 2. Officers of the Board. The Board of Trustees shall elect from its membership a Chairman, a Vice Chairman, and a Secretary for terms of one year during the last day of the annual session following adjournment of the House of Delegates. These officers of the Board shall compose its Executive Committee. The duties of the Secretary may be delegated to the Executive Secretary who shall maintain such special records and transcripts of meetings as the Board may desire.

Section 3. Meetings of the Board. The Board of Trustees shall meet daily during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of any three members of the Board.

Section 4. Executive Committee. The Executive Committee of the Board of Trustees shall be empowered to act in behalf of the Board on all matters delegated to it by majority vote of the Board. The acts of the Executive Committee, however, shall be subject to confirmation by the Board.

Section 5. Reports of the Board of Trustees. The Board of Trustees shall make an annual report to the House of Delegates and such supplemental reports as necessity may require at a time designated in the regular transaction of the business of the House. The report shall be made by the Chairman, the Vice Chairman, the Secretary, or the Executive Secretary. The reports of the Board shall be made a portion of the annual transactions and proceedings of the Association.

Section 6. Duties of Trustees. Each Trustee shall be organizer and arbiter for his Association District. He shall visit the component medical societies within his District during each year and shall make an annual report of his activities and of the condition of the medical profession of each county of his District. Each Trustee shall be reimbursed for expenses incurred by him in traveling within his District or attending special meetings in the performance of his official duties, which will be allowed upon presentation of an itemized and documented account. This provision shall not be construed to include his expenses in attending the annual session of the Association.

Section 7. Public Policy. The Board of Trustees shall have the right to communicate the views of the medical profession and of the Association in the State of Mississippi with regard to matters of medical science, health, sanitation, and allied spheres of activity. It shall approve all memorials and resolutions issued but shall not issue memorials and resolutions heretofore prohibited in these By-Laws.

Section 8. Association Districts. The State of Mississippi shall be subdivided into Association Districts by counties, provided that all counties in a component society shall be in one Association District. These districts are defined as follows:

District 1: Bolivar, Coahoma, Humphreys, Leflore, Quitman, Sunflower, Tallahatchie, Tunica, and Washington.

District 2: Benton, DeSota, Lafayette, Marshall, Panola, Tate, Tippah, and Yalobusha.

District 3: Alcorn, Calhoun, Chickasaw, Clay, Itawamba, Lee, Lowndes, Monroe, Noxubee, Oktibbeha, Pontotoc, Prentiss, Tishomingo, and Union.

District 4: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, and Webster.

District 5: Hinds, Issaquena, Leake, Madison, Rankin, Scott, Sharkey, Simpson, Smith, Warren, and Yazoo.

District 6: Clark, Kemper, Lauderdale, Neshoba, Newton, and Winston.

District 7: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Perry, and Wayne.

District 8: Adams, Amite, Claiborne, Copiah, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, and Wilkinson.

District 9: Hancock, Harrison, Jackson, and Stone.

Chapter IX
COUNCILS

Section 1. Councils. Councils of the Association shall be elected standing bodies of the House of Delegates, responsible thereto. There shall be a Council on Medical Service, a Council on Scientific Assembly, a Judicial Council, a Council on Constitution and By-Laws, a Council on Legislation, a Council on Budget and Finance, an Editorial Council, and a Council on Medical Education. A Council member shall not serve more than two consecutive terms. No mem-

ber shall be eligible for re-election to a Council on which he or she has served two consecutive terms until that individual has been off that council for at least six years.

Section 2. Council on Medical Service. The Council on Medical Service shall be charged with the responsibilities of ascertaining and studying all aspects of medical care in Mississippi. It shall examine and make available all facts, data, and opinion on timely and adequate medical care. It shall investigate social and economic aspects of medical care and report its evaluations and findings. It shall suggest means of distribution of adequate quality medical service to the public consistent with the policies of the Association. It shall act as a factfinding and advisory body of the Association. Under its jurisdictions, there shall be assigned the activities of the Association in medical service, emergency service programs, indigent care, and allied medical agencies. There shall be one member from each Association District elected for a term of three years and so arranged that only three members shall be elected for full terms each year. The Council on Medical Service shall appoint Committees on Occupational Health, Maternal and Child Care, Mental Health, Blood and Blood Banking, and Nursing. Each committee shall consist of not less than five nor more than seven members appointed for periods of not less than one nor more than three years.

Section 3. Council on Scientific Assembly. The Council on Scientific Assembly shall be composed of the Secretary-Treasurer and the chairman and secretaries of the several scientific sections. The Secretary-Treasurer shall be chairman of the Council. Upon this Council shall devolve the duties and responsibilities of planning the annual session to include all scientific activity and the programming and scheduling of annual session events. The Council shall be empowered to appoint such committees for terms not to exceed one year as may be necessary to assist in the discharge of these duties.

Section 4. Judicial Council. The Judicial Council shall consist of nine members elected for terms of three years each, one from each Association District. The Judicial powers of the Association shall be vested in this Council whose decision shall be final. The Council shall have jurisdiction in all questions involving membership in the Association, all controversies arising under the Constitution and these By-Laws, interpretation and application of the Principles of Medical Ethics of the American Medical Association, controversies between two or more component societies of the Association and among members of the Association. The Council shall have appellate jurisdiction in questions and controversies referred to the state Association by appropriate and authorized bodies of component medical societies. Appeals shall be perfected within six months following the date of decision by the constituted authority of the component society. The Council, under these several authorities, may conduct such hearings as may be necessary and after due and legal processes may, by majority opinion, censure, suspend, or expel any member for infraction of the Constitution or these By-Laws.

Section 5. Council on Constitution and By-Laws. The Council on Constitution and By-Laws shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be referred all suggested amendments and changes in the Constitution and By-Laws of the Association for recommendation to the Board of Trustees and House of Delegates.

Section 6. Council on Legislation. The Council on Legislation shall consist of nine members, one from each association district, elected by the House of Delegates for terms of three years each which are so arranged that three members are elected annually. This Council shall analyze proposed legislation, recommending to the Board of Trustees courses of action for securing laws in the interests of public health, scientific medicine, as well as medical practice. It shall study and report the need for new and remedial legislation designed to serve the best interests of the state and nation. This Council shall be responsible to the Board of Trustees.

Section 7. Council on Budget and Finance. The Council on Budget and Finance shall consist of five members elected by the House of Delegates for terms of three years each which are so arranged that not more than two members shall be elected annually. This Council shall receive reports of the finances of the Association and to it shall be referred all matters pertaining to the annual budget. The Council shall report annually to the House of Delegates, making specific recommendations on the annual budget of the Association. This Council shall be responsible to the Board of Trustees.

Section 8. Editorial Council. The Editorial Council shall consist of the Editor and the Associate Editors, elected by the House of Delegates to serve two years, and the former shall serve as chairman. To this Council shall be referred all reports of scientific subjects and all scientific papers and discussions presented before the Association and its component societies. The Council shall consider for publication in the official organ of the Association such papers, reports, and other data as may serve to further and advance scientific medicine in Mississippi. It shall exercise editorial authority over the official organ of the Association. This Council shall be responsible to the Board of Trustees.

Section 9. Council on Medical Education. The Council on Medical Education shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be assigned the responsibilities of encouraging undergraduate and postgraduate study of medicine, licensure, and facilities for medical education in the state. This Council shall be responsible to the Board of Trustees.

Chapter X
COMMITTEES OF THE BOARD OF TRUSTEES

Section 1. Committees of the Board of Trustees. Standing committees of the Board of Trustees shall consist of the Advisory Committee to the Medical Auxiliary, Peer Review Committee, the Committee on Publications, and the Committee on Medicine and Religion. All committees of the Board of Trustees shall be appointed by the Board for terms specified unless their selection is otherwise prescribed.

Section 2. Advisory Committee to the Medical Auxiliary. The Advisory Committee to the Medical Auxiliary shall consist of three members appointed for terms of three years each. The committee shall be charged with the responsibility of advising the Woman's Auxiliary to the Mississippi State Medical Association on matters of organization and program activity relating to the supportive role of the Auxiliary in its work with the Association.

Section 3. Peer Review. The Committee on Peer Review shall consist of nine members, one from each Association district, appointed for terms of three years each so as to provide for appointment of three members annually. Members of this committee shall not simultaneously serve on any disciplinary body of the Association or its component medical societies. To this committee shall be assigned the work of peer review, including but not limited to resolution of differences between patient and physician, review of the quality of medical care, adequacy and/or reasonableness of fees, whether due or paid from private or public sources, utilization of health care resources, and liaison with private and public sources of medical care financing. The committee is empowered to encourage a response from any member of the Association in writing or by personal appearance, authority to initiate investigations on its own motion, and authority to file charges against a member in the name of the committee before the Judicial Council or a disciplinary body of a component medical society. Under no circumstances,

however, shall the Committee on Peer Review exercise any disciplinary function nor shall it be empowered to alter the status or standing of any member. The committee shall be empowered to prescribe its rules of operation which shall not be in conflict with the policies or By-Laws of the Association. The committee shall also encourage and assist component medical societies in forming Committees on Peer Review at the local level.

Section 4. Committee on Publications. The Committee on Publications shall consist of six members. These shall consist of the Editor, the two Associate Editors, and three others, the three latter being appointed by the Board of Trustees for terms of three years which are so arranged to provide for appointment of one such member annually. The chairman of the committee shall be designated by the Board. The committee shall implement instructions and policies of the Board of Trustees relating to the official JOURNAL of the Association. Additionally, the committee shall study and recommend to the Board policy proposals relating to organization and production of the JOURNAL, reporting annually its deliberations.

Section 5. Committee on Medicine and Religion. The Committee on Medicine and Religion shall consist of six members appointed for terms of three years each and so arranged to provide for appointment of two members annually. The committee shall be responsible for formulating a program in the field of medicine and religion and for carrying out such assignments as may be made in this connection by the Board of Trustees.

Section 6. Committee on Long-Range Planning. The Committee on Long-Range Planning shall consist of five members appointed for terms of five years each and so arranged to provide for appointment of one member annually. This committee shall receive charges from the Board of Trustees and shall assess developments and requirements in fields of association activity, making recommendations for courses of action to achieve maximum possible effectiveness in all fields of association activity.

Chapter XI
RULES AND CONDUCT

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

Chapter XII
COMPONENT SOCIETIES

Section 1. Component Societies. All component societies now in affiliation with this Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Board of Trustees and approval by the House of Delegates, receive a charter from and become a component part of this Association. The Board of Trustees and House of Delegates, on recommendation by the Judicial Council, shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

Section 2. Number of Societies. Only one component medical society shall be chartered in any county but nothing in this section shall be construed as to prohibit unofficial organization of medical clubs or other county level groups of physicians whose purpose it is to further and advance scientific medicine and postgraduate medical education.

Section 3. Members of Societies. Each component society shall judge the qualifications of its own members, but as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who is qualified under Chapter I, Section 1, of these By-Laws shall be eligible for election to membership. Before a charter is issued to any component society, full and ample opportunity shall be given to every such physician in the county to become a member.

Section 4. Right of Appeal. Any physician who may feel aggrieved by the action of the society of his county or District in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Judicial Council, which, upon a majority vote, may permit him to petition for membership in an adjacent society.

Section 5. Evidence of Appeals. In hearing appeals, the Judicial Council may admit oral or written evidence, as in its judgment will best and most fairly present the facts, but in case of every appeal, efforts at a conciliation and compromise shall precede all such hearings.

Section 6. Area Jurisdiction. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Section 7. Professional Authority. Each component society shall have general direction of the affairs of the profession in its jurisdiction and shall constantly use its influence to the moral and professional betterment of its physicians, to the end that the membership shall embrace every qualified physician in its jurisdiction.

Section 8. Meetings. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall especially be encouraged to do postgraduate work, and to give the society first benefit of such labors. Official positions and other preferments shall be unstintingly given to such members.

Section 9. Delegates. Each county shall be entitled to representation in the House of Delegates of this Association, one delegate for each fifty members or fraction thereof. Delegates shall be elected for terms of not less than two years and societies shall report such elections to the Executive Secretary of the Association in no event later than thirty days before the annual session.

Section 10. Duties of Component Society Secretaries. The secretary of each component medical society shall perform such duties as are usual and customary to his office. He shall maintain the official roll of membership for his society, shall collect dues and assessments, and shall make official reports as elsewhere prescribed in these By-Laws to the Association, transmitting dues in behalf of component society members. He shall conduct the official correspondence of his component medical society.

Chapter XIII
FISCAL YEAR

The fiscal year of the Association and its component county societies shall begin January 1 each year and end on December 31 following, but membership in the state Association shall not lapse until April 1 of that year.

Chapter XIV
AMENDMENTS

These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, after the amendment has laid upon the table for one day.

Chapter XV
REPEALING AUTHORITY

Upon adoption of these By-Laws, all previous By-Laws, motions of record, mandates, policies, rules and regulations in conflict therewith are hereby repealed, except that officers elected to serve in the Association and its component societies shall continue their incumbency until the completion of their previously prescribed terms and their successors elected under the current By-Laws.



The President Speaking

"AMA Annual Convention"

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

IT WAS MY PRIVILEGE to attend the 124th Annual Convention of the American Medical Association in Atlantic City. Discussions in the reference committees and on the floor addressed themselves primarily to four related topics: the financial crisis within the association, in-house reorganization of the association, medical liability insurance, and the complex issues related to authorized and pending federal legislation on America's health care delivery system.

The House of Delegates voted overwhelmingly to raise dues to $250 per year for regular members and to $35 per year for residents and interns. Dues for medical students will remain at $15. Some cost-cutting procedures were also approved to help put the association back on a sound fiscal basis. The publication, "Prism," will be discontinued, and other publications with the exception of the *JAMA* and *AMA News* will be placed on a subscription basis.

The new president, Dr. Max A. Parrot, recommended several immediate organizational changes that are designed to identify those authorized to speak for the association and give them the authority and flexibility to represent the association with force and candor in the midst of dramatic changes presently under discussion on the nation's health care delivery systems.

The matter of professional liability insurance took a great deal of time and generated much interest. The Board of Directors reported progress on the establishment of an AMA Liability Re-Insurance Facility, and additionally, urged state societies to consider using voluntary arbitration.

As one might expect, national legislation affecting health care evoked strenuous discussions. PSRO, the National Health Planning and Resources Development Act, the Kennedy-Corman Bill all came under careful scrutiny.

In his address to the convention, Dr. Parrot said, "We should want an AMA that will be spirited enough to save the individual spirit of medicine; strong and united enough to counterpoise the strength of centralized medicine; careful enough to preserve the quality of care; and determined enough that medicine will serve no master except service itself."

While we must all regret the need to raise dues, I came away from the convention convinced that the AMA, while imperfect, is still the best hope going for the preservation of independent medicine. Never before have we so desperately needed a unified, determined, and articulate voice on the national scene. It is altogether appropriate that physicians have a say in what shall and shall not be done with the health care system in America. As our parent umbrella organization, the AMA can do a better job in Washington than any of us can do alone. It deserves our continued support. ★★★

JOURNAL OF THE
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EDITORIALS

Thoughts on Recertification

Recertification—a word heard and discussed increasingly often—a tribute to the insistence on excellence and denoting continued competence certainly deserves thought and our best educational minds in any decisions relative to its implementation.

In the past, a medical degree and license by a state board gave a physician the right to practice for a lifetime regardless of his mental or physical health or his competence.

The order is changing and should be. In 1949 the American Academy of General Practice—later Family Practice—was the first to demand reasonable evidence of continued education for sustaining membership.

There is increasing pressure today for recertification and indeed in many specialties criteria are being determined for continued recognition by the respective boards.

The malpractice thrust is one of the factors pressuring for recertification. In the recent debates, confusion, alarm and publicity relative to the prohibitive rates of malpractice insurance, much voice was expressed by segments of the legal profession relative to unqualified medical practitioners. They blamed, to a large extent, the malpractice dilemma on medical incompetence and stated that this element of the medical profession should be exposed and eliminated by its peers. Indeed, they cited a few instances in which these conditions actually existed and the medical community was reluctant and negligent in exposing those guilty.

A second factor is third party pressure, both public and private. As third parties pay an increasing percentage of health care costs, they naturally demand more evidence of competence.

A third factor is the recognition of the problem by the profession itself particularly as related to the "sick doctor." Recent state legislation empowered the State Board of Health to limit or remove the license of physicians who for various reasons are mentally or physically incompetent or obviously should be limited in their scope of practice.

Medicine is not an exact science and there are frequently differences of opinion even among the experts on indicated treatment or surgical procedure.

Change must be gradual and radical moves avoided lest we eliminate some who are able and willing to serve.

W. Moncure Dabney, M.D.
Editor
Crystal Springs, Miss.

Medico-Legal Briefs

LANDMARK DECISION IN MENTAL HEALTH

Insane persons cannot be confined involuntarily if they are not dangerous and can live in the outside world ruled the U. S. Supreme Court on June 26, 1975, in a landmark decision in the history of mental health laws. The court's decision, which proclaimed a constitutional right to liberty for mentally ill persons, came as a result of a suit brought by Kenneth Donaldson and the American Civil Liberties Union.

Donaldson, a carpenter, was seized by the state of Florida and declared insane and dangerous to people. He was subsequently committed to the Florida State Hospital at Chattahoochee in 1957 at the age of 48 at the request of his parents. He remained confined, without treatment, for the next 15 years despite repeated pleas that he was not insane or dangerous. Donaldson's suit followed years of letter writing to doctors, lawyers, politicians and judges.

MEDICO-LEGAL / Continued

According to the court, a mere judgment that an individual is mentally ill "cannot justify a state's locking a person up against his will and keeping him indefinitely in simple custodial confinement." The unanimous decision, written by Justice Potter Stewart, did not deal with the issue of whether the constitution guarantees a "right to treatment" for mental hospital patients. Also deferred in the decision was the degree of liability that must be risked by state hospital officials and psychiatrists who are responsible for keeping non-dangerous persons behind institution walls.

Justice Stewart's opinion for the court also warned that the state may not confine the mentally ill because officials consider the institution more comfortable than living in the community.—*William F. Roberts*



James F. Arens of Jackson and UMC was guest speaker at a respiration and respiratory care meeting in Miami Beach.

Bruce E. Atkinson announces the opening of his office for the practice of internal medicine at 200 N. Third Street in Amory.

Jack A. Atkinson of Brookhaven, MSMA president, was guest speaker before the 44th annual management conference of the Mississippi Hospital Association on the Gulf Coast.

Richard C. Boronow, B. T. Hickman, and J. Tate Thigpen of Jackson and UMC represented the Medical Center at the June Gynecologic Oncology Group meeting in Beverly Hills.

J. C. Goudelock announces the opening of his office for the practice of general surgery in the offices of the Ellis Clinic on Highway 30 West in New Albany.

Sidney O. Graves of Natchez addressed the Natchez Rotary Club recently on his tour of Russia.

Wayne A. Hughes has set up his family practice of medicine at Wiggins Clinic, Ltd., in Wiggins.

Samuel B. Johnson of Jackson and UMC was Lighthouse speaker at the June 7-9 Georgia State Lions convention at Jekyll Island, Ga.

Hendrik K. Kuiper has been named medical director for Kuhn Memorial Hospital in Vicksburg. Dr. Kuiper, a native of Holland, is a Fellow of the Royal Australian College of Surgeons.

Albert L. Laws of Columbus has been certified by the American Board of Ophthalmology.

S. Kimble Love of Vicksburg has been named medical director of the Street Clinic. He assumed his new duties on June 1 and is a pediatrician at the clinic.

Kanwal N. Maniktahla announces the opening of his office for the practice of urology and urological surgery at 362 Lamar Street in Grenada.

Francis S. Morrison and J. Tate Thigpen of Jackson and UMC attended the recent meeting of the Southwest Oncology Group in St. Louis. During this meeting, Dr. Thigpen was elected to membership in the group.

Edward O'Brien has opened offices in the Medical Arts Clinic building in Rosedale for the family practice of medicine.

Glenn B. Richardson announces the opening of his office for the family practice of medicine at G-I, Physicians Mall in Pascagoula.

William C. Sams has associated with G. B. Flagg of Gulfport for the practice of ophthalmology and diseases of the retina at 1317 22nd Avenue.

Ancel C. Tipton, Jr., of Jackson and UMC attended medical thermography meetings in Baltimore.

John J. White of Jackson recently attended the Delegates Meeting of the American Association of Ophthalmology as the representative from the state of Mississippi. Dr. White also participated in the Biennial Cataract Congress in Miami Beach.

T. E. Wilson, III, of Jackson addressed the annual meeting of the Forrest County chapter of The Arthritis Foundation, at William Carey College in Hattiesburg.

Book Reviews

Handbook of Pediatrics. Eleventh Edition. By Henry K. Silver, C. Henry Kempe and Henry B. Bruyn. 705 pages. Los Altos: Lange Medical Publication, 1975. $7.50.

This handbook contains a "gold mine" of information useful to praetieing pediatrieians, family practitioners and house offieers for quiek referenee. Its popularity is borne out by the fact that it has been reprinted in a new edition every two years sinee 1955. The authors are well known in the pediatric field for their knowledge and ability to express important ideas in well organized and easily readable form.

The volume is well indexed which makes it extremely easy to use. The appendix is very helpful for drug doses and lab values important in earing for ehildren. Chapter 32 eoneerns pediatrie proeedures whieh ean help the pediatrie house offieer or refresh the memory of the pediatrieian or family praetitioner for proeedures not often performed.

There are well writtcn sections on pediatrie emergeneies and poisons and toxins. A glance at these seetions would be very helpful in the emergency room. There are well eoneeived graphs and figures whieh quiekly get information across to the reader.

Their description of diseases are preeise and do not leave out "small pearls of information" which often make the differenee in making a diagnosis. The elinical and laboratory findings are well outlined. Thcir information eoncerning treatment is up to date and easily understood. Course and prognosis are also brief and well done.

There are exeellent seetions on Growth and Development and on Nutrition and Feeding which every house offieer should read. It is also refreshing to re-read this material whieh a pediatrician uses every day and still find a wealth of information whieh had slipped away.

It is amazing that the authors havc been able to reduce so much information into sueh a eompact, easily usable volume. I would certainly recommend that all pediatricians and family praetitioners have this eoncise and up to date handbook and feel it is a neeessity for the young intern and first year resident in pediatrics.

Charles A. Sisson, Jr., M.D.
Amory, Miss.

Current Surgical Diagnosis and Treatment. 2nd Edition. By J. Englebert Dunphy, M.D., Lawrence W. Way, M.D., and Associate Authors. 1100 pages. Los Altos: Lange Medical Publications, 1975. $15.00.

Admittedly, a praetieing surgeon rarely has thc time or inclination to launch into the reading of a surgieal textbook, espeeially one of more than a thousand pages. After aeeepting the task of so doing, I ean pass on to the readers of this review that I beeame very familiar with this book. In so doing I ean wholeheartedly reeommend this book to medical students, residents in surgery and praetieing surgeons. This volume of material is well prepared by experieneed surgeons and authors and is presented in a eoneise and informative manner that would enable the casual reviewer to refresh his mind and bring his knowledge to eurrent status about any given subjeet.

In preparing for board examinations in general surgery, this text eould provide an exeellent preparatory review. The text begins with several chapters of general information ineluding pre-operative and post-operative care, wound healing, nuelear medieine, fluid and electrolyte therapy, anesthesia and shock. After dealing with these broad subjeets in a eoneise manner, the authors move on to eaeh anatomieal area of the body and present the disease, diagnosis and eurrent treatment for each.

In summary, this book represents the eombined experience and knowledge of elinieians who have suecessfully transposed this information into a usable form for any of us who might care to improve ourselves as physicians.

Benton M. Hilbun, M.D.
Tupelo, Miss.

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

Sept. 11, 1975

DIABETES SYMPOSIUM

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from the Upjohn Company

Coordinator:
Roland B. Robertson, M.D., director of the University of Mississippi Medical Center Division of Continuing Health Professional Education

Participants will discuss the diagnosis and pathophysiology of diabetes, the juvenile diabetic, management of the adult diabetic, psychiatric problems of the diabetic, and diabetic comas. Registration fee is $15.00.

FUTURE CALENDAR

Oct. 6-10, 1975

EKG ONE-WEEK INTENSIVE COURSE

Nov. 3-5

UROLOGY ONE-WEEK INTENSIVE COURSE

NEW MEMBERS

MURFEE, JOHN A., JR., Columbus. Born Okolona, Miss., Feb. 27, 1938; M.D., Tulane University School of Medicine, New Orleans, La., 1963; interned Charity Hospital, New Orleans, one year; EENT residency rotating between Tulane and EENT Hospital, Ochsner Foundation Hospital, 1966-70; elected by Prairie Medical Society.

ROBERTSON, GERALD M., Hattiesburg. Born Laurel, Miss., Oct. 30, 1943; M.D., University of Mississippi School of Medicine, Jackson, Miss., June 1968; interned Hillcrest Medical Center, Tulsa, Okla., one year; psychiatry residency, Central State Hospital, Norman, Okla., 1969-72; elected by South Mississippi Medical Society.

DEATHS

EDMONDSON, JOSEPH S., Vardaman. Born Vardaman, Miss., Mar. 4, 1910; M.D., Emory University School of Medicine, Atlanta, Ga., 1934; interned Robert B. Green Memorial Hospital, San Antonio, Tex., one year; died May 28, 1975, age 65.

HUTCHINS, JAMES D., Prentiss. Born New Hebron, Miss., June 26, 1908; M.D., Tulane University School of Medicine, New Orleans, La., 1934; interned Southern Baptist Hospital, New Orleans, La., one year; died May 17, 1975, age 68.

ROSS, T. ERSKINE, JR., Hattiesburg. Born Hattiesburg, Miss., Feb. 10, 1894; M.D., Tulane University School of Medicine, New Orleans, La., 1918; interned Methodist Hospital, Hattiesburg, Miss., 2 years; died June 8, 1975, age 81.

LETTERS

SIRS: In the JOURNAL for June 1975, I ran across a full page ad by Blue Cross-Blue Shield. In this ad, a number of claims were made which vary a great deal from my experience with Blue Cross-Blue Shield. Certainly, "ninety-five per cent" are *not* paid within thirty days as described in the advertisement. Also, my date of submission for claims comes a great deal less than the thirty-one days described in the advertisement unless they are "lost" by Blue Cross-Blue Shield.

I am aware that other physicians are likewise unhappy with Blue Cross-Blue Shield in their method of handling claims (reference, latest Psychiatric Newsletter, Mississippi Psychiatric Association). I am in hopes that the association would discontinue accepting advertisements from Blue Cross-Blue Shield.

C. MIMS EDWARDS, M.D.
Brandon, Miss.

SIRS: Recently the Drug Enforcement Administration has received numerous inquiries regarding the validity of DEA registration numbers. Pharmacists have questioned registration numbers on numerous occasions relating to physicians who are employed as

residents, interns, or foreign-trained physicians at hospitals or institutions, and physicians who are on the staff of a Veterans Administration Hospital or a U. S. Public Health Service Hospital.

Federal law and regulations permit an intern, resident, or foreign-trained physician to utilize, in certain instances, the registration number of the hospital where he is a staff member. In such instances, the physician must utilize the hospital's registration number, along with an internal code number which has been assigned by the hospital or institution. The suffix added to the registration number of the hospital may be letters, numbers, or a combination of both (i.e. AP0123456-AX; AP0123456-001; or AP0123456-A2).

The hospital must keep a current list of assigned internal code numbers, and it must be made available to Law Enforcement Agencies upon request for the purpose of verifying the authority of the prescribing individual physician.

Individuals who are members of the staff of a U. S. Public Health Service Hospital may use their social security numbers in lieu of a DEA registration number. If a physician on the staff of the U. S. Public Health Service Hospital utilizes his social security number in lieu of the DEA registration number, it should be on a prescription pad utilized by the Public Health Service Hospital, and the physician's name must be printed, typed, or stamped on the prescription in addition to his signature.

Individuals having questions regarding the validity of DEA registration numbers on prescriptions should contact their nearest DEA office.

JAMES R. BLAND
Regional Director
Drug Enforcement Administration
New Orleans Region

SIRS: *Intramuscular injection of antibiotics may be the tool that will cure salmonella infections and stop salmonella shedding.* Now, according to well-controlled studies reported in the *American Journal of Diseases of Children,** salmonella infections can be successfully treated by intramuscular injections of antibiotics. This work again demonstrates that oral antibiotic is no better than a placebo. In fact, the use of oral antibiotics can prolong shedding and even turn asymptomatic carriers into clinical cases.

Application of this information, if borne out in practice, will do much to prevent intra-familial spread of salmonella; it will avoid the need for long lay-offs of individuals who work with children or in food preparation by ending carrier states. The whole problem of salmonella will become much more manageable.

The article states, "that intramuscular ampicillin produced a 100 per cent bacteriological cure without short-term relapse, needs to be confirmed." The article does not recommend the treatment of carriers. However, intramuscular treatment should not trigger disease in asymptomatic cases, as does oral medication, nor prolong shedding.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

*Garcia de Olarte, et al: "Treatment of Diarrhea in Malnourished Infants and Children, A Double-Blind Study Comparing Ampicillin and Placebo," Am. J. Dis. Child. 127:379-388, March 1974.

Dr. H. C. Ricks Dies in Jackson

Dr. H. C. Ricks of Jackson, retired public health official, died July 4. He was 82.

Dr. Ricks was director of laboratories at the State Board of Health from 1938 until his retirement in 1962. From 1928-1938, he had been director of the division of epidemiology, director of communicable disease control, and in charge of the county health services administration.



Dr. Ricks

In 1963, he was named professor emeritus of preventive medicine at the University of Mississippi School of Medicine in recognition of his strong support for the four-year school and his efforts on behalf of the medical center. Former director-dean Dr. Robert F. Carter credited Dr. Ricks' contribution to the center as a major force in its sound development.

Among the many achievements in his long medical career were presidency of the MSMA, 1956-57; presidency of Central Medical Society, chairmanship of the Public Health Section of the Southern Medical Association; fellowship in the American Society of Clinical Pathologists; and membership in the American Society of Tropical Medicine and Hygiene.

Dr. Ricks served in World War I and during

World War II, he was examining physician for the Selective Service System in Jackson and was a member of the Southern District Appeals Review Board for nearly a quarter century.

He was a founder and past president of the Hinds County Kidney Foundation; a past chairman of Hinds County Red Cross; an elder in the Presbyterian Church and a member of the Lions Club, Jackson Chamber of Commerce and the YMCA.

First 5-State Pediatric Pulmonary Conference Held

The first LAMOT Pediatric Pulmonary Consecutive Case Conference sponsored by the Lung Associations and Thoracic Societies of Louisiana, Arkansas, Mississippi, Oklahoma, and Texas, was held on July 18-19, 1975, in Shreveport at the Chateau Hotel.

The program, acceptable for 9.5 prescribed hours by the American Academy of Family Physicians, was designed for pediatricians and physicians who treat lung diseases and pulmonary problems in young children.

Dr. Suzanne Miller, Director of Cystic Fibrosis Center, Department of Pediatrics, University of Mississippi Medical Center, was Mississippi's Program Co-ordinator and represented the MLA and the Mississippi Thoracic Society. She also presented a series of cases of Bronchiolitis Syndrome and Cystic Fibrosis.

Other topics for case presentations included Dirty Lung Syndrome, Childhood Sarcoidosis, Staphylococcal Pneumonia, and Right Middle Lobe Syndrome.

Other participants included Dr. Charles Ewing, Baylor College of Medicine; Dr. Rosalind Abernathy, University of Arkansas Medical Center; Dr. John Kramer, University of Oklahoma College of Medicine; Dr. Bettina Hilman, LSU Medical School; and Dr. Howard Eigen, Tulane University Medical School.

Visiting guest consultants were Dr. John A. Kirkpatrick, Professor of Radiology, Harvard Medical School and Radiologist-in-Chief, Children's Hospital Medical Center, Boston; Dr. Henry Levison, Associate Professor of Pediatrics, University of Toronto and Director of Respiratory Physiology, The Hospital for Sick Children, Toronto; and Dr. Alexander Spock, Associate Professor of Pediatrics, Duke University Medical Center.

The LAMOT Conference, providing postgraduate opportunities, is part of the medical and professional education program of workshops and seminars made possible by Christmas Seal contributions and Memorial Gift donations. Endorsed by the American Thoracic Society, the name LAMOT represents the five sponsoring state lung and thoracic groups.

Postgraduate Pediatrics Course Held



Family physicians who zeroed in on the special problems of children during a pediatrics intensive course at the University of Mississippi Medical Center included, from left, Dr. Vernon Chase, Baldwyn, Dr. N. E. Murillo Smith, Meridian, and Dr. Ben Kitchens, Ocean Springs. With support from Mississippi Regional Medical Program, the UMC Division of Continuing Health Professional Education sponsored the course.

Mississippi Academy of Family Physicians Elects Officers and Holds Annual Meeting

Dr. Richard T. Furr of Ocean Springs is the new president of the Mississippi Academy of Family Physicians. Dr. Furr was inaugurated during the academy's 27th annual scientific assembly held July 9-12 in Biloxi.

Officers were elected during the business session on Thursday, July 10, and installed at the banquet on Friday evening by Dr. Herbert Holden of San Leandro, Calif., president of the American Academy of Family Physicians. New officers are president-elect, Dr. Walter H. Rose of Indianola; vice president, Dr. Frank W. Bowen of Carthage; and secretary-treasurer, Dr. John M. Estess of Hollandale.

Newly elected directors for 1975-77 are: Dr. William R. Campbell of Columbia, district I; Dr. Ralph L. Brock of McComb, district III; Dr. A. Keith Lay of Bay Springs, district V; Dr. J. Edward Hill of Hollandale, district VII: and Dr. Thomas S. Glasgow of Grenada, district IX.



Dr. Herbert A. Holden, at left, president of the American Academy of Family Physicians, is shown with new officers of the Mississippi academy, from second left, Dr. Richard T. Furr of Ocean Springs, president; Dr. Walter H. Rose of Indianola, president-elect; and Dr. Frank W. Bowen of Carthage, vice president.

Others directors serving the term 1974-76 are: Dr. Edgar D. Johnson of Hattiesburg, district II; Dr. Charles N. Wright of Jackson, district IV; Dr. James W. Allison of Vicksburg, district VI; Dr. W. Arthur Brown of Mathiston, district VIII; and Dr. William B. Howard of Pontotoc, district X.

Elected delegates to AAFP were Drs. Charles R. Jenkins of Laurel and Addison T. Tatum of Petal.

Dr. Norman C. Nelson, Vice Chancellor and Dean of UMC, presented Family Practice Teacher Awards to participating physicians throughout the state who had volunteered their services.

The scientific program, which had been approved



New MAFP president Dr. Richard T. Furr, center, discusses academy policies with Dr. Herbert A. Holden, at left, national president; and Dr. Thomas Anderson of Laurel, immediate past president of the Mississippi academy during the recent convention in Biloxi.

for 14 hours of prescribed credit by AAFP, included presentations on allergic rhinitis in children, renal dialysis in Mississippi, blood gasses, anaerobic infections, orthopedic problems in children, teenage dermatology, diabetes, vaginitis, rheumatology and sonography.

MDs Review Family Medicine at UMC



"What's new—a family medicine review" at the University of Mississippi Medical Center drew family physicians from six southern states. Participants included, from left, Dr. W. T. Mayer, McComb; Dr. William A. Causey, assistant professor of medicine at the University of Chicago Medical School, who served as a guest faculty member; and Dr. Glenn Morris, Clinton. The UMC Division of Continuing Health Professional Education and Department of Family Medicine sponsored the week-long session with partial funding from Mississippi Regional Medical Program.

UMC Announces New Faculty and Promotions

Midsummer medical school faculty promotions and appointments have been announced at the University of Mississippi Medical Center.

Five faculty members moved up to full professor, and 13 others joined the faculty in July and August.

Dr. Norman C. Nelson, vice chancellor for health affairs and medical school dean, announced the changes and appointments following Board of Trustees of Institutions of Higher Learning approval.

Newly promoted to professor are Dr. Allen W. Cowley, Jr., physiology-biophysics; Dr. Allen D. Ashburn, anatomy; Dr. Michael E. Jabaley, surgery, who is chief of the division of plastic surgery; Dr. David G. Watson, pediatrics; and Dr. W. Lamar Weems, surgery, chief of the division of urology.

Promotions to the rank of associate professor went to Dr. J. Lincoln Arceneaux, microbiology; and Dr. Bernard J. Dreiling, medicine; Dr. W. M. Flowers, Jr., radiology; and Dr. Jeanette Pullen, pediatrics.

Moving up to assistant professor are Dr. Robert A. Brace and Dr. James W. DeClue, physiology-biophysics; Dr. W. Harry Gibson, surgery (research); Dr. Rebecca S. Harrell, radiology; and Robert O. Smith, medicine (research).

New appointees include five associate professors, three assistant professors, and five instructors.

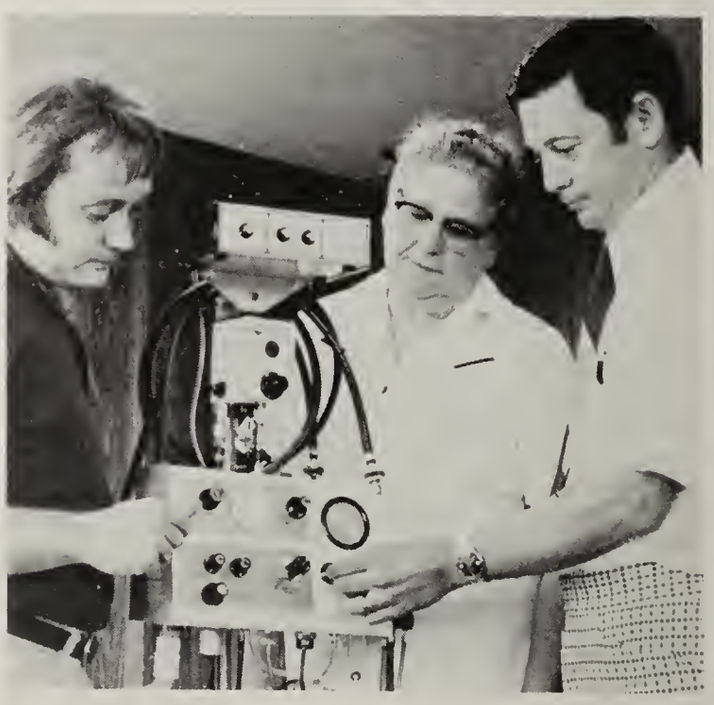
The Department of Psychiatry and Human Behavior, whose new chairman, Dr. Edgar Draper, arrived July 1, will have four new faculty members. Appointees are Dr. Ronald S. Drabman and Dr. William G. Johnson, associate professors; Dr. Julius Collum, assistant professor; and Dr. Maria A. Mastria, instructor.

Other new associate professors are Dr. Ing K. Ho, pharmacology; Dr. Roderick A. Malone, anesthesiology; and Dr. Stanley Weitzner, pathology.

Named assistant professors are Dr. John C. Clay, medicine, and Dr. Orin F. Guidry, anesthesiology.

Joining the medical faculty as instructors are Dr. Richard D. Olsen, pediatrics; Dr. Bruce R. Parks, Jr., pediatrics (pharmacology); Dr. Donald J. Raggio, pediatrics (psychology); and Dr. James E. Strong, medicine.

Ventilator Techniques Studied at UMC



Physicians, nurses, and technicians from Mississippi, Alabama, and Georgia studied ventilation therapy techniques for newborns in a three-day course at the University of Mississippi Medical Center. Participants included, from left, Danny Britt of Tupelo and Dr. Mary Clark and Dr. John R. Jackson of Hattiesburg. The UMC Division of Continuing Health Professional Edu-

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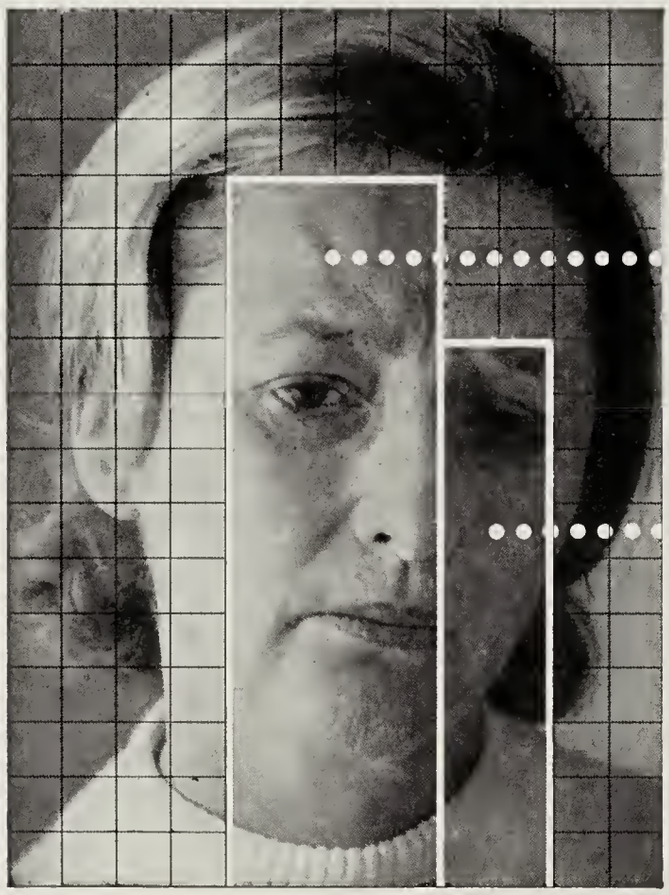
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This Month . . . Diagnostic Radiology.
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ORIGINAL PAPERS

Intra-Aortic Balloon Counterpulsation

THOMAS L. KILGORE, JR., M.D., and
MARTIN H. McMULLAN, M.D.
Jackson, Mississippi

Intra-aortic balloon counterpulsation is a useful tool in the management of patients with acute myocardial infarction and cardiogenic shock. Some of these desperately ill patients can be salvaged by this technique, the basic principles of which are described in the text of this paper.

A VERY HIGH mortality rate in patients with myocardial infarction and cardiogenic shock has been a major stimulus for the development of means of mechanical support of the failing circulation. Much work, some of it promising, is going on related to totally implantable artificial hearts. However, the stage of clinical application of such a prosthesis appears to be quite distant at this point. On the other hand, a certain amount of success has been scored clinically with the use of circulatory assist devices and this will be the subject of this paper.

Myocardial infarction with cardiogenic shock is a morbid clinical entity. In reviewing the pathophysiology of cardiogenic shock, it should be kept in mind that various feedback mechanisms come into play which activate a vicious cycle of diminishing cardiac output and progressive myocardial injury (see Figure 1). As a result of the initial myocardial infarction, contractility and cardiac output may be significantly reduced. To maintain systemic pressure, peripheral vascular resistance will increase. This tends to increase the left ventricular afterload and myocardial oxygen consumption at a time when oxygen supply to the ischemic zone of the heart is sharply reduced. The increased peripheral vascular resistance can also compromise peripheral tissue perfusion and result in lactic acidosis. This acidosis along with the myocardial hypoxemia further reduces cardiac contractility. More rapid deterioration of the metabolism and cardiac function occurs as the regulatory mechanisms that produce increased peripheral vascular resistance begin to fail. At this point coronary perfusion pressure begins to fall which results in an expansion of the zone of ischemia in the myocardium. Consequently cardiac output falls still further potentiating this vicious cycle. Experimental evidence indicates that administration of Digitalis and Isoproterenol can cause an increase in myocardial oxygen consumption leading to an enlarged zone of ischemia. On the other hand, an increase in arterial pressure has been shown to decrease the extent of ischemia injury.[1] These and other similar experimental observations form the basis of the notion that circulatory assist techniques may interrupt the vicious cycle of cardiogenic shock by decreasing myocardial oxygen consumption and increasing coronary perfusion pressure.

The principles underlying intra-aortic balloon counterpulsation (IABC) are relatively simple (see Figure 2). Kantrowitz originally proposed counterpulsation in 1953.[2] His idea was employed by Clauss[3] in 1961. In that effort, the arterial tree was cannulated and arterial blood was then withdrawn during systole and pumped back in during diastole. Moulopoulos and his associates[4] greatly simplified

Presented at 1st Annual Symposium on Heart Disease, Sept. 13-14, 1974, Mississippi Baptist Hospital, Jackson, Miss.

the idea of counterpulsation in 1962 by proposing that a balloon be inserted into the thoracic aorta to be deflated in systole and then inflated during diastole.

The hemodynamic aims of IABC are: to increase myocardial oxygen supply by augmentation of diastolic blood pressure; to reduce myocardial oxygen demand by decreasing the afterload against which the left ventricle must pump; to increase total cardiac output and therefore increase blood flow to peripheral tissues; to lower left ventricular and diastolic pressure and thereby reduce the chance of pulmonary edema. Powell and his associates demonstrated that all of these effects are more prominent when counterpulsation is done in the presence of reduced coronary blood flow than with normal blood flow.[5] When counterpulsation elevates markedly depressed coronary flow, it may actually enhance rather than reduce myocardial oxygen consumption, presumably by improving the oxygen supply to previously under-perfused areas.[6] Braunwald found an average decline of 22 per cent in left ventricular wall stress and a decline of 25 per cent in calculated contractile element work in dogs being subjected to counterpulsation.[7, 8] This reduction in the resistance to left ventricular emptying facilitates myocardial fiber shortening and also results in lowering of myocardial oxygen requirements. Other reported effects of counterpulsation include opening of potential coronary collateral channels[9] and reflex reduction of peripheral vascular resistance, which may contribute to reduction in left ventricular afterload.[10]

Braunwald stated that the experimental myocardial infarction could be significantly reduced in size by counterpulsation initiated just after or as long as three hours after the infarct was produced.[11] Still other studies of an experimental nature claim that while regional coronary flow may be improved by counterpulsation the improvement is to be obtained only if counterpulsation is begun immediately after the infarction is produced.[12] A recent report by DeLaria and associates stated that unless counterpulsation is initiated immediately following infarction, there is no improvement in salvage of myocardium.[13] However, this study did indicate that counterpulsation begun as long as three hours post-infarction would retard the evolution of the infarction. This feature, in the clinical setting, may provide the time necessary to implement more definitive therapy, such as coronary artery bypass.

In the clinical situation, there have been confusing differences in various series of patients which have been presented as cardiogenic shock problems. For instance, a patient with a recent myocardial infarction and shock may be in cardiogenic shock, or he may simply be hypovolemic, a condition with a far superior prognosis. The Swan-Ganz catheter, which can readily be inserted into the pulmonary artery at the patient's bedside, has facilitated identification of hypovolemic shock patients. In both types of hypotension, the systemic arterial blood pressure and cardiac output are depressed and peripheral vascular resistance is almost always increased. In hypovolemic shock patients, however, the pulmonary artery wedge pressure is usually less than 10 mm Hg. On the other hand, patients in cardiogenic shock usually have a pulmonary artery wedge pressure above 18 mm Hg.

Although patients with cardiogenic shock have a poor prognosis, the precise mortality varies from series to series. It is likely that at least part of this variability is the grouping of patients with hypovolemia and hypotension together with those who have true cardiogenic shock following infarction. Knowledge of the filling pressure on the left side of the heart has helped to identify and separate these two confusing groups. To raise the filling pressure of the left side of the heart by infusion of intravenous fluids is often sufficient to increase arterial pressure and cardiac output in the hypovolemic patient. However, fluid replacement in the cardiogenic shock patient is to no avail.

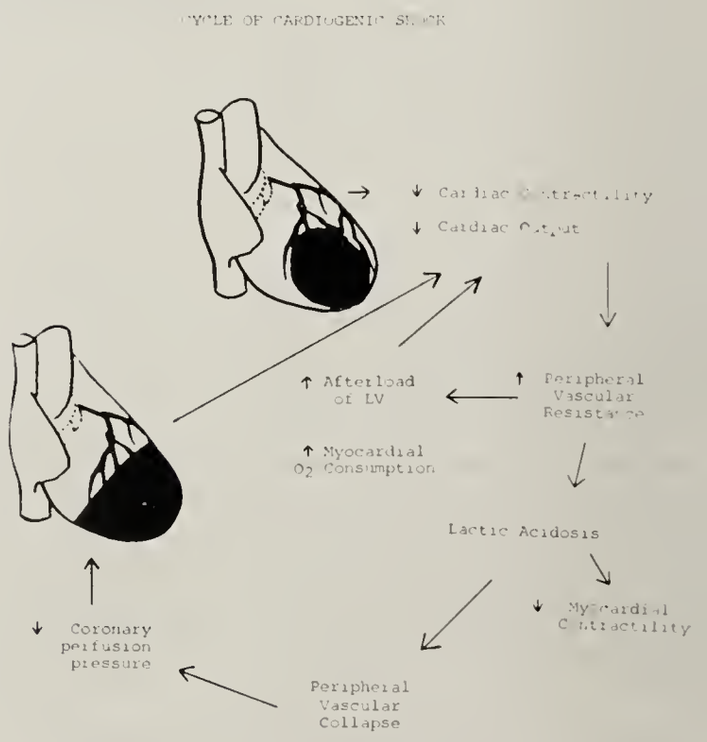


Figure 1. Cycle of cardiogenic shock.

Strictly defined, cardiogenic shock is characterized by: systolic arterial pressure of 80 or less, or 80 mm below the normal systolic blood pressure; a cardiac index of less than 2.1; a urine output of less than 20 cc/hr.; and signs of diminished peripheral perfusion such as mental confusion and cold clammy skin. The mortality rate in true cardiogenic shock so defined is almost 100 per cent.

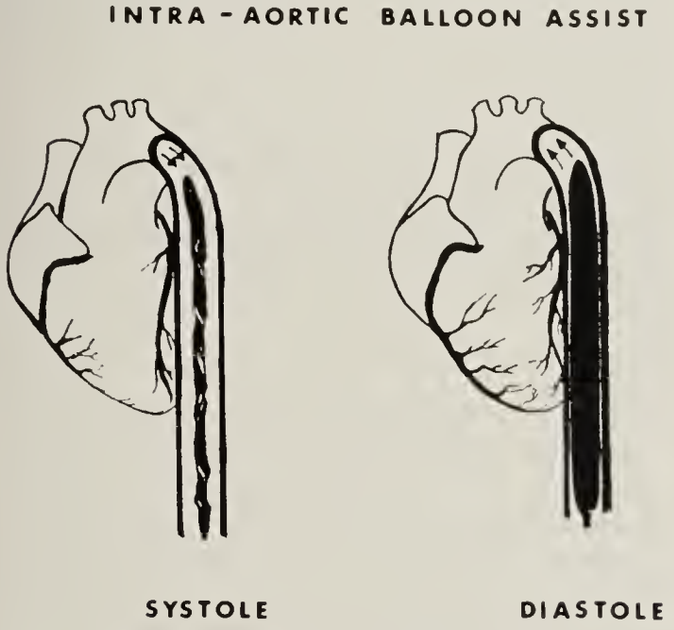


Figure 2. Intra-aortic balloon pump.

Page and his associates have described the pathological changes in hearts of patients who die in cardiogenic shock.[14] That study demonstrated that cardiogenic shock is related to the extent of myocardial damage and that, during prolonged severe shock, continuing focal myocardial necrosis occurs. Their study further demonstrated an intermediate zone of ischemic tissue between clearly infarcted muscle and normal muscle. Cox, et al[15] have shown experimentally that the intensity and size of the zones affected increase with time and that the combined area of necrosis and injury reaches maximal size 18 hours after infarction. Between 18 hours and one week after infarction, the total size of affected muscle remains stable, but the necrotic zone has been shown to enlarge at the expense of the ischemic zone. It is possibly in this intermediate zone that techniques to salvage myocardium may be most fruitful in the prevention and therapy of cardiogenic shock.

In conclusion, IABC is a physiologically sound therapeutic technique resulting in diminished left ventricular afterload and improved coronary perfusion pressure which favorably influences the balance between myocardial oxygen supply and demand. Although most of the physiological data relating to this procedure have been obtained from experimental animals, the ultimate proof of its effectiveness is its application to human subjects. The original aim of counterpulsation in the treatment of the most critically ill patients with cardiogenic shock has been successful in a minority of cases. Greater benefits may perhaps be achieved in "buying time" in these patients while they are studied angiographically and then taken to the operating room for coronary bypass and/or infarctectomy. Early use of IABC to salvage ischemic myocardium in patients with uncomplicated myocardial infarction has become a distinct possibility. ★★★

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Surgically Correctable Complications of Myocardial Infarction

MARTIN H. McMULLAN, M.D., and
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Jackson, Mississippi

RECENT ADVANCES in cardiovascular surgery have provided impetus for an increasingly aggressive approaeh toward the surgical treatment of complications of myoeardial infarction. These complications include thromboembolism, pericardial effusion, permanent complete heart block, left ventricular rupture, intraetable ventricular arrhythmias, ventricular aneurysm, ventricular septal defect, and mitral insufficiency. This report will set forth our philosophy of therapy in eaeh of these areas.

One of the earliest recognized surgically treatable eomplications of acute myocardial infarction was embolization from thrombus material at the site of a transmural infarction. Common sites of embolization inelude the brain, visceral arteries of the abdomen and arteries of the lower extremities. Surgical removal of an embolus to the brain is not performed because of fear of converting an ischemic infarction into a hemorrhagic one with possible fatality. Emboli to visceral arteries, usually of the intestine, all too often are diagnosed at surgieal exploration after gangrenous ehanges requiring resection have oeurred. A high index of suspicion may, on occasion, result in successful diagnosis and early management by embolectomy.

The most eommon site for embolization to occur is the arteries of the lower extremities. A previous history of a recent myocardial infarction (or, incidentally, of atrial fibrillation) coupled with the acute onset of a painful, cool, pulseless extremity is an indication for emergency femoral emboleetomy, usually without any delay to obtain arteriograms. A patient who exhibits embolization from a mural thrombus or in whom a mural thrombus is demonstrated at the time of cardiac catheterization should be plaeed on long term anticoagulant therapy.

Significant pericardial effusion present following myocardial infarction is uncommon. Even more uncommon is the presence of tamponade secondary to this complication. Tamponade secondary to effusion can usually be managed with repeated pericardiocentesis; although rarely, pericardiectomy may be required.

Recent cardiovascular advances have resulted in a more aggressive approach toward surgical treatment for complications of myocardial infarction, say the authors. They give their philosophy of therapy for each of the following complications: thromboembolism, pericardial effusion, permanent complete heart block, left ventricular rupture, intractable ventricular arrhythmias, ventricular aneurysm, ventricular septal defect, and mitral insufficiency.

Myocardial infarction, especially inferior infarction, may be followed by complete heart block, usually transient, but, at times permanent. Our policy has been to observe a post-infarction patient with complete heart block for seven to ten days. If in this period of time he does not revert to a supraventricular mechanism, we then insert a permanent demand pacemaker.

Left ventrieular rupture is another rare complication of myocardial infarction, almost always with a dramatic eonelusion. There have been isolated case reports of repair, in the unlikely event the patient survives, to form a false aneurysm.

Arrhythmia following myocardial infarction oceurs commonly and is most frequently in the form of premature ventricular contractions. These are most often controlled by utilizing intravenous lidocaine, procainamide or quinidine. With the occurrence of ventricular tachycardia or fibrillation these medications and DC countershock may be successfully employed. Rarely, even in the absence of a

Presented at 1st Annual Symposium on Heart Disease, Sept. 13-14, 1974, Mississippi Baptist Hospital, Jackson, Miss.

ventricular aneurysm, ventricular tachycardia or fibrillation may be repetitive in spite of high doses of anti-arrhythmic agents. Excision of the infarction itself has been reported to afford dramatic results.

With the advent of routine ventriculography during coronary arteriography, ventricular aneurysm as an entity may be recognized in as many as 25 per cent of the cases.[1] Usually occurring in association with anterior infarction, the aneurysm involves the anterior wall or apex in 80 per cent of patients.[2] In spite of the increased frequency of diagnosis, the indications for resection have not changed appreciably in recent years. The most common indication for resection remains ventricular dysfunction with associated congestive heart failure. Recurrent ventricular arrhythmia serves as another indication for resection. Thrombus formation within an aneurysm may result in embolization of material with catastrophic results. Resection of the aneurysm with meticulous care to prevent dislodging the thrombus represents the third indication for surgical intervention.

The operative technique for resection of ventricular aneurysm utilizing cardiopulmonary bypass has been standardized in recent years and operative mortality rates of 5 to 15 per cent have been reported.[3] The long term results depend primarily upon the natural history of the underlying coronary artery disease. Only time will allow us to determine if combining aortocoronary bypass with resection of ventricular aneurysm improves longevity.

TABLE I

SURGICALLY CORRECTABLE COMPLICATIONS OF MYOCARDIAL INFARCTION

Thromboembolism
Pericardial effusion tamponade
Permanent complete heart block
Left ventricular rupture
Ventricular aneurysm
Ventricular septal defect
Mitral insufficiency

Post-infarction ventricular septal rupture most frequently occurs near the apex within one week of an anteroseptal infarction. The first clue to diagnosis may be a murmur or more dramatically the acute onset of pulmonary edema or cardiogenic shock. Distinguishing between acute septal rupture and acute mitral insufficiency may present a problem and, at times, can only be resolved by cardiac catheterization. These patients may be so acutely ill as to preclude any formal catheterization procedure. In this situation, a Swan-Gantz flotation catheter is inserted at the bedside into the right ventricle and will confirm the diagnosis of ventricular septal defect if there is a significant oxygen step-up at the ventricular level.

A great deal has been made over the timing of repair in post-infarction ventricular septal defect. With some merit the argument has been made that in the acute situation, surrounding tissues hold sutures poorly. On the other hand, to wait three to six weeks for fibrosis of the margins to occur may prove hazardous. Suffice it to say that if a patient cannot be successfully managed medically, emergent surgery with closure of the ventricular septal defect is indicated. If one is afforded the luxury of stabilization for a three to six week period, the chances of a technically more satisfactory effort are enhanced.

The incidence of this complication following myocardial infarction is only 0.5 to 1 per cent but the mortality is extremely high; 24 per cent die within 24 hours and 87 per cent within two months.[5] Therefore, large surgical series are not available. There were three deaths in 16 patients who underwent post-infarction ventricular septal defect repair at the Mayo Clinic for an operative mortality of 19 per cent.[6] In this series the interval between occurrence of myocardial infarction and operation ranged from three weeks to 34 months, reflecting a certain degree of patient selection. The Stanford Group reported 12 patients who underwent emergency closure of post-infarction ventricular septal defect one to seven days following infarction with an operative mortality of 50 per cent.[7] The increased mortality in the Stanford series probably emphasizes the point that those who undergo emergency surgery are gravely ill, while those having elective closure have been well enough to survive several weeks.

Mitral insufficiency following myocardial infarction more commonly is due to papillary muscle rupture or dysfunction, although ruptured chorda tendineae, ventricular dilatation or formation of a ventricular aneurysm may be causative as well. Ruptured papillary muscle is heralded clinically by the acute onset of an apical systolic murmur with abrupt and often intractable left ventricular failure or cardiogenic shock. The mortality of this complication has been reported as 70 per cent within 24 hours and 90 per cent within two weeks.[8] Papillary muscle dysfunction generally develops more slowly but the end hemodynamic effect is the same. As mentioned previously, the diagnosis can be difficult to differen-

tiate from post-infarction ventricular septal defect and may require cardiac catheterization. The diagnosis is substantiated upon finding an elevated pulmonary wedge pressure or pulmonary artery diastolic pressure with a large V-wave.

The indication for surgery is usually quite obvious and, as recommended for any patient being considered for mitral valve replacement, should be performed before irreversible ventricular impairment takes place. Because of the rapidly progressive course in many patients, the mortality for mitral valve replacement in this group is understandably high when compared to elective replacement. The Mayo Clinic group reported 26 patients who underwent mitral valve surgery for post-infarction mitral insufficiency with eight hospital deaths for an operative mortality of 31 per cent.[9] Their elective mortality for this same period of time was 10 to 12 per cent.

To discuss results from other institutions is beneficial in gaining information as to a standard of excellence for the sake of comparison to one's own results. However, these latter three complications which present most dramatically and which account for rather high mortality even with surgical intervention occur uncommonly. No one institution has a large experience upon which to call. We have encountered and dealt with most of these complications but only infrequently. Therefore, it seems prudent to present our data in closely related areas.

Since our unit opened three years ago, we have performed more than 700 procedures utilizing cardiopulmonary bypass. Approximately 65 per cent of these procedures have been aortocoronary bypasses. From Jan. 1, 1972, to Nov. 30, 1974, 33 patients have undergone mitral valve replacement with three hospital deaths for an operative mortality of 9 per cent. Two of these patients were found to have ruptured cordae as the etiology of their mitral insufficiency. There was no incidence of ruptured papillary muscle secondary to myocardial infarction in our series. The low operative mortality in part can be attributed to our philosophy of early valve replacement in mitral insufficiency before irreversible ventricular impairment occurs, a philosophy championed by Dr. John Kirklin of Birmingham.

In combined aortic and mitral valve disease, we have replaced both valves in 8 patients with no operative mortality. Obviously when numbers are this small, even one death can change the mortality column drastically. Such is the case in resection of ventricular aneurysms. We have performed this procedure in eight patients with two hospital deaths for an operative mortality of 25 per cent. Five of these patients also underwent aortocoronary bypass at the same operation.

Certainly congenital ventricular septal defect cannot be compared to post-infarction ventricular septal defects. Even though in general the congenital defects present a much greater technical challenge, the post-infarction ones are usually present in a much more critically ill patient. These patients not only have a ventricular septal defect, but ischemic or nonviable myocardium contributing to varying degrees of ventricular dysfunction. We have closed congenital ventricular septal defects in 15 patients without a death.

SUMMARY

Life threatening surgically correctable complications following myocardial infarction, fortunately, are uncommon. However, when these complications do occur it is imperative that an accurate diagnosis be made with expediency in order to provide the surgeon with a still salvageable situation. In this event mortality from these complications of myocardial infarction can be reduced dramatically. ★★★

1600 North State Street (39202)

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Radiologic Seminar CLIV: The Expanding Role of Diagnostic Radiology

JOHN Y. GIBSON, M.D.
Jackson, Mississippi

RADIOLOGY HAS BEEN defined as that branch of medical science which uses radiant energy in the diagnosis and treatment of disease. Diagnostic radiology is, of course, the subspecialty of radiology limited to diagnosis. The term "radiant energy" usually refers to energy from the emission of electromagnetic waves such as those of light, x-ray and gamma rays or the emission of charged particles such as alpha and beta particles. The limitation of radiology to the use of radiant energy is no longer appropriate. To appreciate the evolution of such a change we need to briefly look at the past.

Wilhelm Konrad Roentgen, Professor of Physics and Director of the Institute of Physics in Wurzburg, Germany, formally announced his discovery in late December 1895 in a manuscript entitled "On a New Kind of Rays." Not only other physicists but electricians and photographers alike quickly adopted this new form of experimentation. In the December 1908 meeting of the American Roentgen Ray Society Dr. Percy Brown of Boston described the early investigation of x-ray as "a sort of Joseph's coat of many colors which fitted no one. The attendant wires and sparks suggested an electrician's work, surely; . . . but there were the plates, darkroom and chemicals, considered usually the accessories of the photographer. Neither of these artisans, on the other hand, could be expected to intrude themselves so far into the realms of medicine as to offer a diagnostic verdict. The electrician after dallying in the darkroom with chemicals, produced photographic results of no higher quality than might be expected of an electrician; the photographer, after producing a generous display of pyrotechnics in the immediate vicinity of the patient, finally met with a practical electrical problem quite beyond his depth; while the surgeon, albeit well versed in all heretofore employed methods of diagnosis, skillfully cut for a renal stone in an endeavor to find what was in reality, the elusive suspender button."[1] Such a state of affairs led some physicians to fully dedicate their time to the field of "x-ray diagnosis" thus establishing a new medical specialty.

The practical diagnostic work in the first few years was concerned with the evaluation of fractures and the localization of foreign objects. Later the use of contrast agents provided visualization of the gastrointestinal tract, bronchial airways, urinary tract, spinal canal and the heart and blood vessels. The addition of image intensification greatly improved the fluoroscopic image and allowed more accurate monitoring of contrast studies to insure better recorded information and to permit better evaluation of the dynamic aspects of the examination. During this period of development the radiologist was considered an "x-ray doctor" and rightfully so, since all of this diagnostic ability was directed toward the interpretation of images produced by x-rays.

Soon after Roentgen's discovery of x-ray, Henri Becqueriel discovered the natural radioactivity of uranium. Thirty-eight years later the development of artificial radioactivity by Frederick Joliot and Irene Curie prepared the way for the commercial production of radioactive isotopes. It was not until 1946, however, that radioisotopes were produced in sufficient number to be used in research. This was made possible by converting to civilian use nuclear reactors that had been producing materials for nuclear weapons during World War II. In 1951 the isotope scintillation scanner was developed and put to clinical use examining the thyroid of patients who had received radioactive iodine (I131). The images recorded were obtained from the pattern of gamma ray emission by the isotope concentrated in the patient's thyroid gland. This expanded use of

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From the Department of Radiology, University Hospital, Jackson, Miss.

radiant energy released the radiologist from the limited role of "x-ray doctor" and allowed him to interpret information recorded for visual display that was not produced by x-rays.

From these modest beginnings radiology has evolved into an ever broadening and more complex specialty that uses not only x-rays but radioactive isotopes, positrons, protons, neutrons, pi mesons, heat and high frequency sound to produce its images. The computer is also being adapted to use in radiology as it is in most other technical fields. By the recent combination of the computer and body section radiography an image can now be produced that provides visualization of the separate portions of the brain without the introduction of a contrast agent.[2] This method of "computerized axial tomography" is also being developed for use on other areas of the body.

A subspecialty making rapid inroads into clinical diagnosis is the relatively new field of diagnostic ultrasound.[3] By the use of high frequency sound waves echoed from internal structures, images of body parts are displayed on oscilloscope and TV screens. Since this system is highly sensitive to changes in tissue density, useful diagnostic information can be obtained without the administration of contrast media or the invasive insertion of catheters. Also, since sound waves in the frequencies used are not known to cause any harmful interaction with body tissues, studies can be performed repeatedly on the same patient without concern for overexposure to potentially dangerous radiation. The diagnostic radiologist has come into this field naturally by his training and experience in the interpretation of images. Although the ultrasound scans and echograms are not produced by "radiant energy," their production is a result of an energy in wave form with physical properties similar to electromagnetic waves and the scans display the anatomy in a manner somewhat similar to isotope scanning.

Perhaps a more appropriate definition of diagnostic radiology would be: "that branch of medical science which deals with the production and interpretation of graphic or pictorial images that provide information useful in clinical diagnosis." We continue our role of one who attempts to make sense of the shadows but now the shadows are often made by ways other than by x-ray.

Where do we go from here? The future is just as unpredictable now as it was in 1895, but there seems



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to be a prevailing direction of change that deserves comment. The trend appears to be in the direction of less invasive and less harmful methods of obtaining useful diagnostic information. With the development of ultrasound as applied to cardiology some of the information previously gained only by cardiac catheterization can now be obtained by echocardiography.[4] In fact, some of the information concerning mitral valve anatomy and function recorded on the echocardiogram can be obtained by no other means.

Then there is acoustical holography.[5] A hologram is the ripple pattern produced on a liquid surface by vibrating waves that is "read" by a laser beam. "Acoustical" holography uses high frequency sound (ultrasound) passed through a portion of the body to produce the ripple pattern (hologram) on a liquid medium that can be read by a laser beam and displayed on a TV screen. The result is an improved real-time image of the anatomy without the use of contrast agents or invasive techniques. Much research is presently being conducted on this and similar imaging systems which may be the prototype of future "fluoroscopic" equipment that does not require the use of radiation.

While it is unlikely that x-rays will ever be totally replaced as a means of producing images for diagnostic information, it does seem highly probable that in the future some if not many of the common radiological procedures will be replaced by non-invasive, non-ionizing forms of image production. There will undoubtedly continue to be an ever increasing amount of diagnostic information retrievable from improved imaging systems that will allow radiology to continue to contribute significantly to the rendering of quality patient care. ★★★

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The President Speaking

"What Can I Give?"

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

IN THESE TIMES, I am disturbed by the growing emphasis on rights and the lessening concern for personal responsibility. Less and less often do we hear "what can I give" and more and more frequently are we assailed by the demand "what can I get." This attitude of self seeking has proliferated, I believe, as our society has become more affluent and, I am sure, since our government has become more centralized and more powerful.

As parents we are anxious to give our children the necessities of life and as many of the luxuries as we can afford, and in the process many have learned only how to take and have not learned how to give.

The same is true in this age of governmental paternalism. A larger and larger segment of our population is withdrawing into an ingrowing obsession for personal security and much of the freedom for which so many, in the recent and distant past, have sacrificed so heavily is being surrendered in return for government-directed and government-apportioned security.

"What can I give" is becoming "what can I get" and in the very demands for rights we stand a good chance to lose the very rights that give worth and dignity to man. ★★★

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EDITORIALS

A Salute to Alcoholics Anonymous

Some of the finest Christian people I know are alcoholics. Many of them have not had a drink in five years or longer but readily admit they are just one drink away from being drunk. They have come from the depths of despair to assume a new life dedicated to helping other alcoholics.

Once an alcoholic expresses an earnest desire for help, and turns to AA, he immediately comes under the influence of a group of people who, all former alcoholics, will give unstintingly of their time, efforts, and finances to see that he stays sober and is started on the road to rehabilitation.

The preamble used in AA meetings states, "Alcoholics Anonymous is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problems and help others to recover from alcoholism."

"The only requirement for membership is an honest desire to stop drinking. AA has no dues or fees. It is not allied with any sect, denomination, politics, or organization or institution; does not wish to engage in any controversy, neither endorses or opposes any cause. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety."

There are nine to ten million alcoholics in the United States. Alcoholism is an illness and is treatable. As physicians, we need all the help available for treating alcoholics and AA stands ready to aid us at any time, day or night.

We physicians owe to the AA a debt of gratitude and a sense of admiration for total dedication toward solving a most difficult problem. Ladies and gentlemen, we salute you.

GEORGE H. MARTIN, M.D.
Associate Editor
Vicksburg, Miss.

Medico-Legal Briefs

The following is a summary of the position and recommendations of the Association of Trial Lawyers of America on the subject of medical malpractice.

SUMMARY OF THE SEVEN POINTS OF RESPONSIBILITY FOR QUALITY MEDICAL CARE— THE CITIZEN'S RIGHT

1. Guaranteeing Availability of Malpractice Insurance. In the few states where insurers have threatened to cancel policies or withdraw from the market, the public interest requires that such insurance be made available to physicians. If insurers are unable to devise a plan informally that would guarantee such availability, legislation should be considered. That legislation might require every insurer selling casualty insurance to share in the underwriting risks (or reinsurance risks) for medical professional liability insurance, as well as appropriate assigned risk programs for that insurance.

2. Maintaining Reasonable Insurance Rates. While the total malpractice insurance premiums are not excessive when compared with the total incomes earned by physicians, there is a severe malapportionment of premium charges which causes some physicians to pay a disproportionate part of the total costs. This problem can be substantially reduced by eliminating all rating classifications between supposedly different risk medical specialties. Legislation can establish that rates will be assessed as a percentage of the gross revenues of each physician (or at a level premium rate for all physicians). Greater equity will then be provided to all physicians, including the new physician who has not yet developed a full practice and the retiring physician who wishes to maintain only a part-time practice. Such legislation would also control unjustified surcharges that increase premiums when non-meritorious claims are

asserted against a physician. It might also provide for mandatory inclusion or mandatory offering of deductibles, so the physician can save premiums by accepting some of the risk himself, and by preventing a physician from blocking a settlement for emotional reasons when the insurer knows that a settlement is economically more sensible. Together, these procedures would produce more reasonable premiums, while distributing the costs more equitably among the physicians.

3. Professional Liability Insurance Efficiency. While there are no reliable statistics to establish the portion of the insurance dollar which reaches the injured patient, we believe that a larger part of the insurance dollar is spent on proving and defending malpractice cases than is spent in other casualty insurance lawsuits. Insurers for physicians defend these cases much more vigorously, so that very few cases are settled before suit and an unusual portion are actually tried to a conclusion in court. The cases are complex and expensive. To reduce these costs, screening panels should be established in an effort to eliminate non-meritorious cases early. In the few cases involving great damage to the patient with large amounts in dispute, both sides are entitled to a full court trial. Compulsory binding arbitration should be considered in cases involving less than $25,000 as an efficiency measure. Arbitration lacks many safeguards and equities, but it does provide greater speed and economy.

4. Contingent Fee Regulation. Any proposal to eliminate or severely restrict contingent fees would serve principally to prevent injured patients with meritorious cases from asserting their rights. Very few injured patients could retain competent counsel if they were forced to pay for legal services on a time basis. These cases are long, complicated, and expensive. Personal injury trial lawyers are usually reluctant to undertake these cases at all. Unless competent counsel are given an opportunity to earn fees consistent with their efforts, patients with meritorious cases will not obtain proper representation. Regulation of fees should never be undertaken on the theory that it will reduce the number of claims against physicians, since a patient's ability to hire a competent lawyer should never be impaired. If fee regulation is considered for the protection of the patient (not the gratification of the physician), care should be taken to make sure that attorneys are not discouraged from handling these cases by stringent limitations on their fees. The public interest is ill-served when insurers refuse to sell malpractice insurance. It is equally ill-served when qualified attorneys are difficult to retain to represent patients.

5. Legislative Reinsurance Programs. Catastrophic losses and large payments are extremely rare in the medical professional liability field, despite misleading statements to the contrary. If there is real concern about such catastrophic losses, a state reinsurance or catastrophic loss fund can be established to pay such losses above a minimum catastrophe limit. That fund can be supported collectively by all casualty insurers in the state (or by a governmental fund collected from general revenues) without any substantial impact on the budget of casualty insurers (or the state budget). That procedure would lessen the apprehension by health care providers about the catastrophic loss and their need to buy insurance against such catastrophic loss.

6. Modification of Legal Doctrine. A few misinformed critics have argued that special legal rules in malpractice cases are responsible for increasing malpractice insurance premiums. They point to legal rules like *res ipsa loquitor* (the Latin equivalent for "it's obvious") and the requirement for informed consent. These legal rules serve a valid public purpose as the courts adopting them have explained in great detail. Further, they have little or no effect on malpractice insurance premiums. With rare exceptions, these doctrines are not the basis for recovery. Nor are they applied only in medical malpractice cases. Physicians should be treated like all other litigants, no better and no worse. The application of these legal doctrines should be a matter that should be decided by the courts in appropriate cases.

7. "No Fault" and "Workmen's Compensation Type" Malpractice Claims. Most of the proposals that are given these names have no semblance to a non-fault remedy or a workmen's compensation law. They require the patient to prove that the injury resulted from the physician's malpractice in the same way that he must prove it now. However, they require that these cases be decided by an administrative agency where less safeguards are available to either side, and they severely limit the amount of compensation the injured patient can obtain after proving his damages in that fault claim. These proposals are probably unconstitutional, and they are certainly unfair to the patient. Any system which provides a real non-fault remedy would probably have stratospheric costs, since there are literally hundreds of medical injuries for every person who now receives payment in a fault claim. Furthermore, the fault system has proved to be a powerful stimulant

for improved medical care. Without it, society will have lost an important means of encouraging quality care.

NEW MEMBERS

CHANDLER, RODNEY R., Hattiesburg. Born Texarkana, Tex., May 9, 1947; M.D., University of Arkansas School of Medicine, Little Rock, Ark., 1973; interned Charity Hospital, New Orleans, La., one year; elected by South Mississippi Medical Society.

OWEN, WILLIAM DOUGLAS, Raleigh. Born Gulfport, Miss., Oct. 17, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1972; interned Madigan Army Medical Center, Tacoma, Wash., one year; elected by South Mississippi Medical Society.



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†The exceptions: Alaska, Arizona, Maine, Oregon, Rhode Island, and the District of Columbia



SBH Announces Statewide Hypertension Program

The Mississippi State Board of Health's hypertension control program offers two areas of service for the care and treatment of any hypertensive patients physicians may wish to refer.

In the *joint supervision system* the health department will conduct monitor or follow-up examination on patients and perform selected lab work, as requested, forwarding results to the physician. The patient will be required to have a monthly blood pressure check at the health department. If two monthly visits are missed, the health department will make contact to encourage compliance through counseling. SBH will furnish any of the available services, including drugs, if desired. Under the provisions of the grant SBH will undertake to see that third party and private source funds for services and drugs are used effectively. Nothing in the present program, however, is intended to impose any conditions which would require charges for services to people unable to pay, nor to provide revenue for the health department. This means, for example, that any patient receiving Medicaid benefits, or funds from any other third party source, will be given a prescription for his drugs in order that these may be obtained from the pharmacy of his choice, according to Dr. Durward Blakey, chief, Bureau of Disease Control.

In the *total health department supervision system* the health department will take over the total care and control of the patient, at the physician's request, for hypertension.

The SBH is offering these services for the hypertensive patient:

Lab Tests: AA3 (BUN, Creatinine, Uric Acid); Coulter (CBC, Blood Indices); Electrolytes (except CO2); Glucose; Urinalysis; Cholesterol.

Other Services: EKG; X-Ray; Drugs; Monthly blood pressure check.

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Medicare Updates Allowable Charges

Travelers Medicare of Mississippi has announced that newly updated allowable charges for fiscal year 1976 (July 1, 1975, through June 30, 1976) became effective in July. During fiscal year 1975, allowances have been based on charges for services rendered in calendar year 1973. New allowable amounts (which are the lesser of customary charge or the prevailing charge for a particular service or supply) will be based on charges for services and supplies provided during calendar year 1974. These new fiscal year allowances will be applicable until July 1976.

One of the provisions of Section 224 of Public Law 92-603 (the 1972 Social Security Amendments) was that *prevailing* charge levels used in determining Medicare allowances for physicians' services may be increased above the level for fiscal year 1973 (calendar year 1971 data base) only to the extent determined justified by the Secretary of the Department of Health, Education and Welfare on the basis of appropriate economic index data. The fiscal year 1973 allowances were based on 1971 calendar year charge data.

This economic index limitation will apply *only* to increases in *prevailing* charges and *only* to *physicians'* services. It will not affect customary charge allowances. The law established prevailing allowances for fiscal year 1973 as the base for measuring all future increases. The Department of Health, Education and Welfare has announced that the economic index calculated for each fiscal year will reflect on a cumulative basis the changes that have taken place in physicians' practice expenses and general earnings levels since calendar year 1971. The economic index for fiscal year 1976 will be 17.9.

Book Reviews

Acupuncture Anesthesia. Reproduced by the Geographic Health Studies Program of the John E. Fogarty International Center, 1975.

The Fogarty International Center has been publishing documents on various aspects of medicine in different countries of Europe and the Far East. This book was translated from the Chinese publication of the same title. "Acupuncture Anesthesia" was produced by the People's Republic of China to serve as instructions to paramedical personnel as well as physicians.

This rather lengthy book, 339 pages, attempts to cover the subject of acupuncture anesthesia starting with history of anesthesia and concluding with an investigation into the theoretical principles of acupuncture anesthesia. The book is certainly not very deep from a medical viewpoint but leans very heavily toward China's traditional medicine. The theories of Tsang-Fu (The Theory of Organs and Bowels) and Ching-Lo (The Theory of Meridians) are fully discussed, and it was at this point that this reviewer got totally lost in the traditional medicine of China.

The bulk of the book is occupied by a detailed account of the acupuncture points in all their complexity. The application of acupuncture in the various forms of surgery, with numerous "case reports," occupies over 100 pages of this book. The points for nose acupuncture, facial acupuncture and ear acupuncture are described in great detail.

I would assume that upon completion of this dull, lengthy book, which also contains some propaganda, all one needs are acupuncture needles and a willing patient. You may then dispose of your anesthesia machine and stop worrying about anesthetic toxicity. A few gourds, herbs and snake oil might also be helpful.

JAMES H. SAMS, M.D.
Columbus, Miss.

Acupuncture Anesthesia in the People's Republic of China, 1973. By James Y. P. Chen, M.D. 105 pages with illustrations. Washington, D. C.: HEW, $1.80.

This is another publication of the John E. Fogarty International Center. There is a difference between therapeutic acupuncture and acupuncture anesthesia. This monograph was prepared by Dr. Chen in an attempt to provide Americans with a general view of acupuncture anesthesia. Toward this end, he has done a good job.

The foreword of the book contains a summary by Dr. John Bonica. There is also a good list of references for the reader who wishes to go deeper into the subject.

This is an excellent book for the average doctor to read to get a good overview of the subject.

JAMES H. SAMS, M.D.
Columbus, Miss.

PERSONALS

WILLIAM K. AUSTIN, JR., has associated with VERNER S. HOLMES of McComb for the practice of ear, nose and throat, nasal allergy, maxillofacial and facial plastic surgery at the Southwest Mississippi ENT Clinic, 405 Marion Avenue.

T. O. BAILEY has associated with the Medical Clinic of Canton, P.A., in family practice at 153 E. Center Street, Canton.

RODNEY W. BAINE has associated with JACK SARTIN of Clarksdale for the practice of general, thoracic and vascular surgery with offices in the Stevens Building.

LEONARD D. BALL has joined the medical staff at Memorial Hospital in Gulfport for the practice of child psychiatry and general psychiatry at offices in the Security Savings Building, Suite 605.

MALCOLM D. BAXTER, JR., of Hernando announces the association of ROY DEMENT for the practice of medicine and surgery at Baxter Clinic, 170 Holly Springs Street, N.E.

RICHARD L. BLOUNT of Jackson has been re-elected to the Board of Directors of the National Society for the Prevention of Blindness.

EDMUND H. CRANE, JR., announces the relocation of his office to 1308 44th Avenue in Gulfport for the practice of internal medicine and cardiology.

PERSONALS / Continued

H. Davis Dear and McKamy Smith of Jackson announce the association of Morris E. Williams for the practice of cardiology at 1600 North State Street.

I. C. Fernando has opened his practice of obstetrics and gynecology at Ellis Clinic, 105 East Jordan Avenue in West Point.

Steven B. Fineburg announces the opening of his office for the practice of general medicine at 4211 Hospital Road, Doctor's Plaza, Suite 303 in Pascagoula.

P. S. Ganaraj announces the opening of his office for general surgery and general practice at 1213 Magnolia Avenue in Tylertown.

Gary G. Gordon has associated with Rush Medical Group, P.A., for general practice at 1314 19th Avenue in Meridian.

Glen Graves has associated with the Children's Clinic at 876 A Lakeland Drive in Jackson for the practice of pediatrics.

Michael Hellman announces the opening of his office for family practice at the Medical Plaza on Vancleave Road in Ocean Springs.

M. E. Hinman of Vicksburg is the new president of the Vicksburg Rotary Club.

Donald A. Hopkins announces the relocation of his office for the practice of general surgery to Gulfport Surgical Clinic, 1245 Broad Avenue in Gulfport.

C. G. Hull, III, has associated with The Radiology Associates, P.A., in Laurel at Jones County Community Hospital for the practice of radiology.

Jimmy E. Isbell has joined the Rush Medical Group, P.A., of Meridian for the practice of pediatrics at 1314 19th Avenue.

Hansel Janet and G. Robert Robinson of Gulfport announce the relocation of their offices to 0450 Pass Road.

William Kahlstorf has associated with Obstetrics and Gynecology Associates, P.A., of Tupelo for the practice of obstetrics and gynecology at 607 Brunson Drive.

Ray Kimble announces the opening of his office for the practice of psychiatry at Suite 405, Weinberg Building, Washington Avenue in Greenville.

John P. Lee of Forest announces the association of D. Chan Henry in the general practice of medicine at Offices on First Street.

Roger L. Lowery has associated with Harold K. Hudson of Tupelo at Tupelo ENT Surgical Clinic, 618 Pegram Drive for practice limited to ear, nose, and throat; head and neck; facial plastic surgery and allergy.

Roger B. Marlin will open his office for the family practice of medicine in the Spraberry Building in Fulton.

William H. Meyer announces the opening of his office for the practice of orthopaedic surgery at Medical Arts Building, 300 Rawls Drive in McComb.

Patrick G. McLain of Vicksburg announces the relocation of his office to The Corner Medical Center at 1117-23 Washington Street.

F. Lamar McMillin, Jr., has associated with The Vicksburg Clinic in the department of family practice.

S. Ray Pate of Jackson is now a Fellow of the American Psychiatric Association.

James John Purdy has associated with the Rush Medical Group, P.A., for the practice of obstetrics and gynecology at 1314 19th Avenue in Meridian.

Fraciano P. Sison, Jr., has located in Pontotoc for the practice of general surgery.

G. C. Stubblefield, Jr., has associated with Jackson Medical Associates, P.A., for the practice of hematology, oncology and internal medicine at the Medical Plaza Building, 1600 North State Street in Jackson.

Van H. Temple has associated with Drs. Nix and Berry, P.A., at 878 Lakeland Drive in Jackson for the practice of orthopaedic surgery.

David R. Thomas announces the opening of his office at Medical Arts Clinic, 517 University Drive in Starkville for the practice of general adult medicine and diseases of the chest.

Frank W. Wilburn has associated with Charles P. Tharp and M. M. Winkler, Jr., of Tupelo for the practice of pediatrics at Infants, Children and Adolescent Clinic, 804 West Garfield Street.

Louie F. Wilkins announces the association of Richard Gerald Burris in the family practice of Medicine at 215 Hwy. 51 South in Brookhaven.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P-M-A

POSTGRADUATE CALENDAR

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers a series of intensive refresher courses designed to meet physicians' clinical practice needs in the specialties most requested. Mississippi Regional Medical Program partially supports the series open to all physicians regardless of race, creed, color, religion, sex, age, or national origin.

Intensive courses are eligible for American Medical Association Physician Recognition Award Category I credit. Enrollment is limited, and applications are accepted in the order received. Cost is $25.00 per day or $125 per week, depending on the course length.

INTENSIVE COURSE CALENDAR

HEMATOLOGY
Oct. 6-10, 1975
Jan. 12-16, 1976

HEMATOLOGY
Oct. 21-22, 1975

INFECTIOUS DISEASES
Oct. 30-31, 1975

NEPHROLOGY
Jan. 26-30, 1976
April 19-23, 1976

ONCOLOGY
Oct. 23-24, 1975

OTOLARYNGOLOGY
Mar. 3-5, 1976

PEDIATRICS
Nov. 10-14, 1975
Mar. 22-26, 1976

PULMONARY MEDICINE
April 5-9, 1975

UROLOGY
Nov. 3-5, 1975
Feb. 23-25, 1976

Inquiries about or advance registration for the intensive courses should be addressed to Division of Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson 39216.

FUTURE CALENDAR

Sept. 5-6, 1975

CONTACT LENS SEMINAR

Addie McBryde Rehabilitation Center for the Blind, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education and School of Medicine Department of Surgery, Division of Ophthalmology

Coordinator:
Delmar R. Caldwell, M.D., assistant professor of surgery ophthalmology), the University of Mississippi School of Medicine

This two-day seminar is open to Mississippi ophthalmologists and will cover the subject of contact lens. AMA Category I Physician Recognition Award credit will be given. Course fee is $30.00.

Sept. 11, 1975

DIABETES SYMPOSIUM

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education and the School of Medicine with support from the Upjohn Company

Coordinator:
Roland B. Robertson, director, University Medical Center, Division of Continuing Health Professional Education

Participants will discuss the diagnosis and pathophysiology of diabetes, the juvenile diabetic, management of the adult diabetic, psychiatric problems of the diabetic, and the diabetic comas. Guest faculty will include Dr. John A. Colwell, Medical University of South Carolina; Dr. Luther Travis, University of Texas Medical School at Galveston; Dr. David Kipnis, Washington University School of Medicine; and Dr. Gene G. Abel, University of Tennessee Center for Health Sciences, Memphis. Course fee is $15.00.

Oct. 3, 1975

ENTEROSTOMAL THERAPY
Greenville

Sponsored by the University of Mississippi School of Nursing and the University Medical Center, Division of Continuing Health Professional Education with partial support from the American Cancer Society and Mississippi Regional Medical Program

Coordinator:
Jan Evers, RN, MN, director of continuing education, the University of Mississippi School of Nursing

This program is designed for physicians and nurses who care for patients with colostomies, ileostomies, or urostomies. Focus will be on indications for surgery, types of surgery, and postoperative, long-term management of the ostomates. Course fee is $10.00.

Oct. 6-10, 1975

EKG Intensive Course
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinator:
Thomas M. Blake, M.D., professor of medicine and chief of the cardiology division and of electrocardiography, the University of Mississippi School of Medicine

Discussions and demonstrations related to pragmatic clinical electrocardiography will deal in fundamentals of understanding and perspective but avoid details of electrophysiology. The course is designed for the practicing clinician, internist or family practitioner, who uses electrocardiography in the daily routine. The study is aimed at increasing his understanding of EKG and updating his knowledge of instrumentation. Participants are encouraged to bring problem tracings for discussion. Course fee is $125.00.

Oct. 21-22, 1975

Hematology Intensive Course
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinators:
Francis Morrison, M.D., associate professor of medicine, the University of Mississippi School of Medicine

J. Tate Thigpen, M.D., assistant professor of medicine, the University of Mississippi School of Medicine

This two-day course reviews recent advances in the basics of diagnosis and treatment of hematologic disorders. Fee is $50.00.

Oct. 23-24, 1975

Oncology Intensive Course
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinators:

Francis Morrison, M.D., associate professor of medicine, the University of Mississippi School of Medicine
J. Tate Thigpen, M.D., assistant professor of medicine, the University of Mississippi School of Medicine

The two-day course is designed to update the primary care physician in advances in oncology, which now includes the word "cure" for certain neoplasms. Participants will cover the role and principles of chemotherapy and discuss details of handling patients receiving immunosuppressive therapy, with emphasis on side effects. Course fee is $50.00.

Oct. 30-31, 1975

Infectious Diseases Intensive Course
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education, with partial support from Mississippi Regional Medical Program

Coordinator:
William Lockwood, M.D., associate professor of medicine, the University of Mississippi School of Medicine

Course emphasis will be on diagnostic procedures, antimicrobial agents, virology, anaerobic infections, common bacterial infections, and epidemiology. Fee is $50.00.

ADVANCE CALENDAR

Nov. 3-5, 1975
Urology Intensive Course
Nov. 10-14, 1975
Pediatrics Intensive Course

TB Demonstration Program Implemented

The current management of tuberculosis indicates that the majority of tuberculosis patients can be adequately managed on an outpatient basis, and patients requiring hospitalization can be effectively treated in selected general hospitals. To determine the applicability of these concepts in Mississippi, a special demonstration project has been developed, announced Dr. Alton B. Cobb, State Health Officer.

Effective Aug. 1, 1975, cases of diagnosed or suspected tuberculosis, residing in the counties listed below, who require hospital care will be hospitalized at the Delta Medical Center (formerly The General Hospital) in Greenville instead of the Sanatorium: Attala, Bolivar, Carroll, Coahoma, DeSoto, Grenada, Holmes, Humphreys, Leflore, Montgomery, Panola, Quitman, Sunflower, Tallahatchie, Tate, Tunica, Washington, Yalobusha.

The Delta Medical Center is located at 1400 E. Union Street, Greenville, telephone no. 378-3783.

Dr. John R. Williams will function as the Medical Consultant for the project, and hold a regularly scheduled tuberculosis clinic at the Washington and Bolivar County Health Departments. Dr. Williams is in private practice, limited to pulmonary disease, in Greenville and a member of the medical staff of Delta Medical Center. Mrs. Ida Fuquay will function as Public Health Nurse Coordinator and will have an office at the hospital. She will serve as a liaison between the hospital and county health departments in the project area. Dr. Williams will be available for telephone consultation regarding cases of diagnosed or suspected tuberculosis who may need hospitalization. He may be reached at telephone no. 332-8169.

Patients needing hospitalization should be referred to the county health department for preparation of the necessary forms and arranging for admission to the Delta Medical Center. The regular sanatorium admission forms will be used until a permanent form can be developed. However, the Board of Supervisors guarantee of payment is not needed since hospital costs will be paid by the project. The admission form, a copy of the patient's record, and chest x-rays should be sent with the patient to the hospital.

While it is anticipated that many tuberculosis cases can be managed on an outpatient basis, hospitalization should be considered for: 1) patients too ill to be treated on an outpatient basis; 2) patients for whom a diagnosis cannot be readily established; 3) patients without an acceptable outpatient treatment plan; 4) patients needing re-treatment therapy and close observation for possible toxic effect of second line anti-tuberculosis drugs.

Patients will be discharged to the care of their private physician or the county health department. As quickly as arrangements can be made, regularly scheduled tuberculosis clinics will be conducted through several county health departments in the project area with a qualified chest consultant in attendance. Patients with suspected tuberculosis may be referred to these clinics for diagnosis and treatment. (A list of these clinics giving the location, date, and time will be made available at a later date.) If hospitalization is indicated, the patient will be referred to the Delta Medical Center as set forth above.

This project is intended to further unify and strengthen the tuberculosis control program in Mississippi. It is being directed through the State Board of Health, Tuberculosis Control Unit, and enjoys the active support and involvement of the University Medical Center, Mississippi State Sanatorium, and the Mississippi Lung Association. Visiting consultants who will be actively involved with the project include Dr. Joe R. Norman, director of Division of Pulmonary Diseases, University Medical Center; Dr. Lee R. Reid, Medical Consultant, Tuberculosis Control Unit, State Board of Health; and Dr. Clyde A. Watkins, Superintendent, Mississippi State Sanatorium.

Questions concerning the project may be directed to the Tuberculosis Control Unit of the State Board of Health, telephone no. 354-6663 or the county health department. Physicians' cooperation and assistance will be appreciated in the first organized effort to treat tuberculosis in a general hospital in Mississippi, said Dr. Cobb.

Florida Internists Meet Oct. 31-Nov. 2

Specialists in internal medicine and related medical fields will hold a three-day scientific meeting on Oct. 31-Nov. 2, 1975, at Innisbrook, Tarpon Springs, Fla.

Physicians who attend the regional meeting are eligible for credit toward the American Medical Association Physicians Recognition Award in Category #1.

In charge of arrangements for the Florida Regional Meeting is Dr. Leighton E. Cluff, Gainesville, who serves as the ACP's representative in the state of Florida.

Council on Scientific Assembly Announces The Format for 108th Annual Session

Preliminary plans for the 108th Annual Session of MSMA to be held during May 3-6, 1976, have been made by the Council on Scientific Assembly which met in Jackson on July 23, according to Dr. James P. Spell of Jackson, chairman.

On the annual session meeting agenda are the House of Delegates and reference committees for Monday with the final meeting of the policy-making body again scheduled for Thursday morning.

The nine scientific sessions will offer top guest essayists with emphasis on instate participation. On Sunday night, May 2, the Section on Anesthesiology will meet. Tuesday morning, May 4, will feature simultaneous meetings of the Section on Surgery and the Section on EENT. That afternoon the Sections on Medicine, Radiology and Pediatrics are scheduled to meet. On Wednesday morning the Section on Family Physicians will present a program and that afternoon will feature the Section on Ob-Gyn and the Section on Preventive Medicine.



The Council on Scientific Assembly is shown at work during the annual summer planning meeting held at MSMA headquarters in Jackson.

Dr. Spell said that as many as 15 specialty societies and related groups will meet during the annual session, usually selecting a day adjunctive to general scientific meetings concerned with the particular specialty. Of further interest will be specialty society luncheons and dinner occasions.

The Woman's Auxiliary will meet concurrently with the MSMA annual session for its 53rd annual session. Mrs. J. Edward Hill of Hollandale is president.

Dr. Spell said medical alumni groups representing Ole Miss, Tulane, Tennessee and Vanderbilt are scheduling social occasions for Monday, May 3.

Special events will include the Fifty Year Club luncheon and Past President's breakfast. The annual association party is set for Tuesday, May 4.

Delegates will meet on Monday to receive reports and resolutions which will be discussed before reference committees that afternoon. Dr. Jack A. Atkinson of Brookhaven, MSMA president, will open the convention. The Nominating Committee will conduct open sessions on Wednesday, and on Thursday, the House of Delegates will take final actions on business and policy, electing 1976-77 officers as the final order of business.

Dr. Lyne S. Gamble of Greenville, president-elect, will be inaugurated 1976 president of the association at the adjourned meeting of the House of Delegates, and new officers will assume their respective posts at that time.

Technical and scientific exhibits will also be featured during the four-day annual session.

LETTERS

SIRS: I would like to take this opportunity to express appreciation of the entire staff of the American Medical Association for the President's Page in the August 1975 JOURNAL MSMA which summarizes the 1975 Annual Convention and supports the need for an AMA dues increase.

Dr. Atkinson's comments are in keeping with the spirit of Mississippi and enthusiasm for medical unity as expressed by your fine staff and the physicians I have met from your state. We deeply appreciate these voluntary comments and hope the AMA will continue to carn your support in the never ending battle against federal control of patient care.

RICHARD G. LAYTON
Assistant Director
Public Affairs Division
American Medical Association

DEATHS

CROCKER, OTTIS B., Bruce. Born Sarepta, Miss., April 25, 1906; M.D., Tulane University School of Medicine, New Orleans, La., 1935; interned US Marine Hospital, Norfolk, Va., one year; died June 17, 1975, age 69.

LEWIS, WILEY D., Meridian. Born Woodland, Miss., Feb. 6, 1908; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1931; interned Baptist Memorial Hospital, Memphis, Tenn., one year; died June 19, 1975, age 67.

NOBLES, WILLIAM W., Tunica. Born Flora, Miss., Nov. 25, 1901; M.D., Washington University School of Medicine, St. Louis, Mo., 1928; interned St. Louis City Hospital, St. Louis, Mo., one year; died July 3, 1975, age 73.

PEEPLES, ROBERT H., Greenville. Born Tiptonville, Tenn., Nov. 12, 1915; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1942; interned Nix Hospital, San Antonio, Tex., one year; radiology residency, Methodist Hospital, Memphis, Tenn., 1943-46; died April 21, 1975, age 59.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension
Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

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A division of Pfizer Pharmaceuticals
New York, New York 10017

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Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig

Please see prescribing information on facing page.

Medical Center Announces New Faculty

Eight new faculty members have joined the staff of the University of Mississippi School of Medicine at the Medical Center.

Dr. Robert A. Sanford is an assistant professor of neurosurgery, and Dr. Linda R. Walters is an assistant professor of pediatrics.

New instructors are Dr. John Foster Fields, Dr. Guillermo Julio Ruiz Orrico, and Dr. Vannarth Sumathy, obstetrics-gynecology; Dr. Mac Andrew Greganti and Dr. Taira Morino, medicine; and John Henry Pfifferling, family medicine.

Vice Chancellor Dr. Norman C. Nelson announced the appointments, effective in July and August, following Board of Trustees of Institutions of Higher Learning approval.

Dr. Sanford, who completed a two-year tour of duty in the U. S. Army, did a residency at University Hospital in Jackson from 1968 to 1973. He holds a B.A. degree from Hendrix College, Conway, Ark., and earned his M.D. degree at the University of Arkansas School of Medicine, Little Rock. He did his internship at the University of Minnesota Medical Center, Minneapolis.

Dr. Walters is a former assistant professor at the University of Kentucky School of Medicine, Lexington, where she also served as a resident, fellow, and instructor. She received a B.S. degree from Indiana State Teachers College, Terre Haute, and her M.D. degree from Indiana University School of Medicine. Dr. Walters interned and did a residency at St. Vincent's Hospital in Indianapolis.

Dr. Fields holds B.A., M.S., and Ph.D. degrees from the University of Mississippi, having received the doctorate of philosophy in June 1975. He joins the Department of Ob-Gyn as a research scientist.

Former staff physician at Hospital Privado, Cordoba, Argentina, where he did an internship and a residency, Dr. Orrico got his M.D. degree from Cordoba's National University. He also has a B.S. degree from Monserrat National College of CNU.

Dr. Sumathy had been an instructor at the University of Missouri School of Medicine, Kansas City. With M.B.B.S., D.G.O. and M.D. degrees from Madras Medical College, Madras, India, the new faculty member interned at Madras Medical College Hospital and served as a resident at the Institute of Obstetrics and Gynecology, Madras, and at Kansas City General Hospital.

A University of Mississippi School of Medicine alumnus, Dr. Greganti got his degree in 1972 and interned at Strong Memorial Hospital, University of Rochester, N. Y., where he also completed two residencies. He earned a B.S. degree at Millsaps College.

Dr. Morino, who was in private practice in Japan for two years, earned the M.D. degree and did postgraduate training at Kyoto Prefectural University, Kyoto, Japan. The physician interned and did a residency at Albert Einstein Medical Center, Philadelphia, Pa., was a resident at the University of Mississippi Medical Center from 1971 to 1972, and was a fellow at Henry Ford Hospital, Detroit.

For the past year, Pfifferling had served as a medical anthropologist with the Joint Commission on Accreditation of Hospitals, Chicago. He has also been an instructor at the University of Maine, Pennsylvania State University, Cleveland State University, and Adelphi University. He holds a B.A. degree from Hunter College and did postgraduate work at Pennsylvania State University.

UMC Haralson Memorial Loan Fund Established

The $200,000 Bertha H. Haralson Memorial Medical Education Loan Fund to the University of Mississippi Medical Center "will help medical students for generations to come," according to UMC Vice Chancellor Dr. Norman C. Nelson.

Dr. M. Flint Haralson of Sarasota, Fla., retired public health officer and alumnus of the two-year medical school at Oxford, designated the gift as a memorial to his late wife.

In presenting the gift, through the University of Mississippi Foundation, Dr. Haralson said, "A host of friends and admirers throughout the United States and abroad share with me the memory of an outstanding woman whose personality, charm, and love have influenced the lives of those she has known."

"We are grateful to Dr. Haralson and proud of his support of medical education and confidence in this medical school," Dr. Nelson said.

Dr. Haralson was born in Conehatta and grew up and attended public school in Forest. He received his B.S. degree in 1911 from the University of Mississippi.

In 1913, he was awarded a certificate from the

two-year medical school and went on to the University of Virginia to earn his M.D.

A year later, he joined the U. S. Public Health Service and served in more than 20 locations in this country and abroad before his retirement in 1950.

Overseas, he served as quarantine officer to prevent the spread of smallpox and typhus to this country. Dr. Haralson actively participated in controlling the bubonic plague outbreaks in New Orleans and Mobile in 1919.

The Haralsons were married during World War I when both were employed by the Public Health Service in Washington, D. C. A native of Grand Haven, Mich., Mrs. Haralson died May 29, 1974.

Native Mississippians in the School of Medicine who show financial need are eligible for loans from the fund of $500 each, Dr. Nelson said.

Repayment—made within three years after completion of formal medical education—insures perpetual loan funds for students.



University of Mississippi Chancellor Porter L. Fortune, Jr., right, and UMC Vice Chancellor Dr. Norman C. Nelson, left, accept the gift designated as a memorial to the late Mrs. Haralson from Dr. M. Flint Haralson.

Internists Will Meet in Nashville

Specialists in internal medicine and related medical fields will hold a two-day scientific meeting on Oct. 24-25, 1975, at the Hyatt Regency in Nashville, Tenn.

Physicians who attend the regional meeting are eligible for credit toward the American Medical Association Physicians Recognition Award in Category #1.

In charge of arrangements for the Tennessee/Kentucky Regional Meeting is Dr. Gerald I. Plitman of Memphis, who serves as the ACP's representative in the state of Tennessee.

No Solutions Appear to Energy Problem

High energy costs are rapidly becoming the major inflationary cost in conducting business, according to the small and medium size enterprise. This is indicated in the answers respondents recently gave to a survey conducted by the National Federation of Independent Business.

Respondents were asked to rate out of 13 causes of inflation in their operations those ranking the highest. Of the total, 94.3 per cent said the cost of energy. This is only topped by the 95 per cent who gave the cost of goods and materials as the biggest inflationary cost. Inasmuch as most goods and materials are energy intensive and thus their prices reflect higher energy costs, it seems apparent that energy is the chief culprit for the inflated costs of operation and thus the major reason for higher consumer prices.

The NFIB findings seem to suggest that mounting energy costs could become the Achilles heel in the drive to cut down on inflation which is considered the primary current problem by independent business people.

Not as clear-cut are the views of independent business on how to solve the problem created by higher energy costs. While there seems to be a general agreement that no branch of government is taking effective steps in this direction, the independent business people themselves seem uncertain as to what course should be followed.

Separate surveys recently conducted for the NFIB find that 37 per cent believe the pricing mechanism of the market should be relied upon to solve the problem, while 35 per cent feel there should instead be rationing of energy. But when respondents were asked their preference between rationing and an oil tax, 27 per cent opted for rationing, and 42 per cent for an oil tax.

AAFP 1975 Assembly Set for Chicago

A wide choice of continuing education courses will be offered to U. S. family physicians at the American Academy of Family Physicians' Annual Scientific Assembly scheduled Oct. 6-9 at Chicago's McCormick Place.

The 27th annual meeting held especially for family doctors provides nine separate program elements. Medical lectures include presentations by 18 nationally-known speakers on practical, up-to-date information such as "Caring for a Family's Inherited Disease," "Making Sense Out of Heart Murmur," and "Abdominal Pain in Children."

Highlighting the medical lecture program will be the lead-off speaker, Dr. Otis Bowen, governor of Indiana and an academy member. Dr. Bowen's state passed landmark legislation to control malpractice premiums in the spring.

Continuing education courses, popular new features of last year's assembly, this year will include subjects such as interactional analysis, office gynecology, human sexuality, electrolyte problems, and testing techniques for the American Board of Family Practice certification examination.

"Dialogue," another popular 1974 innovation, will consist of informal discussions involving some 100 physicians, conducted by one or more medical school faculty members. There will be 14 "Dialogue" groups meeting during the four-day assembly.

Topics covering the gamut of situations confronting today's family doctor will be offered in clinical seminars, two-hour sessions limited to 15 physicians. Live Teaching Demonstrations will be presented on such topics as dermatology, back examinations and self-examinations of the breast by faculty members of medical schools in the Chicago area. Closed-circuit television monitors will provide all in the audience "examining table" closeness.

In other demonstrations, participants will observe techniques to prevent athletic injuries and allow motion or activities after injuries have occurred. Methods of applying casts to simulated broken extremities also will be demonstrated.

Among the seven topics offered in the Programmed Instruction Courses are infant nutrition, gonococcal infections, drug interaction, and alcoholism.

Scientific and technical exhibits will provide a great source of information on research projects, new equipment, services and pharmaceuticals.

Physicians will earn one hour of prescribed AAFP continuing education credit for each hour of participation in any element of the scientific program, except for the viewing of exhibits. The academy requires a minimum of 150 hours of continuing education every three years in order to maintain membership.

Prior to the scientific meeting, the academy's Congress of Delegates will meet to conduct official business of the 37,000-member academy. The congress will meet Saturday, Sunday and Monday morning, with the final session highlighted by the election of officers. The congress will convene at Chicago's Palmer House, the headquarters hotel.

The AAFP Fellowship degree will be conferred upon 1975 candidates in McCormick Place's Arie Crown Theatre Tuesday night, Oct. 7. In the accompanying inauguration of officers, Dr. Carl B. Hall, Charleston, W. Va., will become president of the academy.

Dr. J. P. Culpepper, Jr. Dies in Hattiesburg

Dr. J. P. Culpepper, Jr., of Hattiesburg, who had a long career of active service in state and national medical organizations, died August 4. He was 78.

Dr. Culpepper had served as president and secretary of the South Mississippi Medical Society, was a member of the Gulf Coast Clinical Society, was a member of the MSMA Board of Trustees in 1940-42, and served as chairman of the MSMA Grievance Committee from 1956-62. He served as state medical delegate to the AMA from 1951 to 1967. In 1962-63 Dr. Culpepper was vice president of the AMA and in 1963 he was appointed to fill an unexpired term on the AMA Board of Trustees.



Dr. Culpepper

The Hattiesburg physician held numerous offices in the Southern Medical Association including councilor for Mississippi, vice president and president for the term 1956-57. He was a member of the

Board of Directors of the Mississippi Academy of Family Practice and a member of the American academy.

Dr. Culpepper, a graduate of the Tulane University School of Medicine, was a member of the Mississippi State Board of Health from 1942-47. He practiced in Hattiesburg from 1925 until his retirement.

Also active in civic affairs, he was a past president of the Hattiesburg Kiwanis Club, a member of the Hattiesburg Civic Association, past president and king of the Krewe of Zeus, and a deacon in the First Baptist Church of Hattiesburg.

Dr. Curtis Caine Receives Service Award



At the recent MSMA 107th Annual Session in Biloxi, the Mississippi Society of Anesthesiologists presented an outstanding service award to Dr. Curtis W. Caine of Jackson, shown at left receiving the engraved plaque from MSA president Dr. Carlos Patino of Jackson. The award was presented to Dr. Caine "in grateful recognition of his outstanding service to the practice of anesthesiology in the state of Mississippi."

Internists Will Study Hypertension

The American College of Physicians (ACP) will sponsor a three-day postgraduate course entitled "A New Look at the Hypertensions" on Oct. 2-4, 1975, in Oklahoma City, Okla. The course, held in conjunction with the University of Oklahoma Health Sciences Center, will take place at the Skirvin Plaza Hotel.

The program is designed to help the physician update his concepts of the broad considerations that underlie the multiplicity of problems that afflict patients with hypertension, including the endocrine, renal, and cardiovascular areas. Additional time will be devoted to an understanding of the new diagnostic techniques and therapeutic advances.

The American College of Physicians postgraduate courses have been approved by the American Medical Association Advisory Committee on Continuing Medical Education, and may be used to fulfill Category #1 requirements for the AMA Physicians Recognition Award.

Director of the Oklahoma City postgraduate course is Dr. Edward D. Frohlich. The course is being planned under the co-direction of Dr. Dale Groom and Dr. Solomon Papper.

For Information and Registration write Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Endocrine, Metabolic and Genetics Studied

The American College of Physicians (ACP) will sponsor a four-day postgraduate course entitled "Endocrine, Metabolic and Genetic Disease: Clinical Application of Basic Advances" on Oct. 20-23, 1975, in Durham, N. C. The course will be held in conjunction with the Duke University Medical Center.

The course is designed to provide the clinician with an understanding of some of the recent advances in biochemistry, physiology, and genetics as they apply to a variety of endocrine and metabolic disorders.

The American College of Physicians postgraduate courses have been approved by the American Medical Association Advisory Committee on Continuing Medical Education, and may be used to fulfill Category #1 requirements for the AMA Physicians Recognition Award.

Director of the Durham course is Dr. Harry T. McPherson. The course is being planned under the co-direction of Dr. James B. Wyngaarden.

For Information and Registration write Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Nephrology Is Studied at Medical Center



Latest concepts in diagnosing and treating patients with renal disease provided discussions for a week-long course in nephrology at the University of Mississippi Medical Center. Family physicians who took the course included, seated, from left, Dr. Judson Lloyd of Natchez, Dr. William Truly of Canton, and, standing, Dr. Max L. Pharr and Dr. Charles Guess, both of Jackson. The UMC Division of Continuing Health Professional Education sponsored the course with partial support from Mississippi Regional Medical Program.

Cardiovascular Disease Conference Slated

A continuing education conference on Oct. 22-24, 1975, in Bethesda, Md., will be on advances in research and therapy in cardiovascular disease and their applicability for practicing physicians.

Among the researchers presenting new data on etiology and therapeutic techniques are Drs. Frederic Bartter, Thomas Bersot, William Roberts, David Redwood, Lawrence Friedman, Kenneth Kent, Gerald Payne, Manning Feinleib, and Walter Henry from the National Heart and Lung Institute. Among the speakers in clinical practice are Dr. Karel Absolon, chairman of the Department of Surgery at Washington Hospital Center, Dr. Herbert Tanenbaum, Assistant Professor of Clinical Medicine, Georgetown University, and Dr. William Bell, Associated Professor of Medicine, Johns Hopkins University. As part of the scheduled sessions, participants may discuss findings with the speakers.

In addition to papers, participants will visit and hear descriptions of research in five sites in the Clinical Center of National Institutes of Health, The National Library of Medicine, and the experimental laboratory of the Washington Hospital Center. Dr. W. Proctor Harvey, chairman of the Division of Cardiology of Georgetown University, has invited participating physicians to his Cardiology Conference on Thursday evening.

A full list of topics and speakers as well as information about continuing medical education credits may be obtained from Dr. Jean K. Boek, director of the Division of Special Studies, National Graduate University, 3408 Wisconsin Avenue, N.W., Washington, D. C. 20016, 202/966-5100.

Family Doctors Study Hematology, Oncology



Recent advances, diagnosis, and treatment were topics of discussion for family physicians in the hematology/oncology intensive course at the University of Mississippi Medical Center. Participants included, seated, from left, Dr. Jerry Welch of Laurel, Dr. Charles A. Marascalco of Vicksburg, and, standing, Dr. Nathan Feibelman of Andalusia, Ala., guest lecturer Dr. James George of the University of Texas Medical School at San Antonio, and Dr. Ben O'Kelly of Weir. The UMC Division of Continuing Health Professional Education sponsored the course with Mississippi Regional Medical Program support.

Preventive Medicine Studied at Memphis

The American College of Physicians (ACP) will sponsor a five-day postgraduate course entitled "Preventive Internal Medicine: The Internist's Role in the Prevention and Modification of Acute and Chronic Diseases" on Oct. 13-17, 1975, in Memphis. The course will be held in conjunction with the University of Tennessee Department of Medicine.

The course is aimed at bringing the internist up-to-date as to his potential in preventing acute diseases and intervening in the course of chronic ones. It will deal with all of the recognized subspecialties in internal medicine: cardiology, pulmonary disease, renology, gastroenterology, allergy and immunology, infectious disease, hematology, oncology, rheumatology, and endocrinology.

The American College of Physicians postgraduate courses have been approved by the American Medical Association Advisory Committee on Continuing Medical Education, and may be used to fulfill Category #1 requirements for the AMA Physicians Recognition Award.

The course is being planned under the direction of Dr. Gene H. Stollerman. Associate directors are Dr. Charles E. Kossmann and Dr. Stanley B. Kaplan.

For Information and Registration write Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Coast Athletic Injury Seminar Held

The annual Gulf Coast Athletic Injury Seminar was held on Aug. 7 at Howard Memorial Hospital in Biloxi.

Over 60 coaches, trainers and team physicians from the Gulf Coast area attended the conference. Guest speaker was Jim Gillispie, assistant trainer at the University of Southern Mississippi, who presented a film on rehabilitation and discussed on-the-field and locker room management and rehabilitation of injuries.

Local physicians on the program and their topics included: Dr. Ray L. Wesson, heat stress; Dr. Tom Garrott, skin problems; Dr. Victor Bazzone, head and neck injuries; Dr. Hal Bishop, upper extremity injuries; and Dr. John O'Keefe, lower extremity injuries.

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JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

OCTOBER 1975

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
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ORIGINAL PAPERS

Changes in Handling Pulmonary Tuberculosis

LEE R. REID, M.D.
Jackson, Mississippi

Within the last few years, major changes have occurred in the handling of tuberculosis. Powerful antituberculosis drugs have profoundly influenced the thinking with regard to several formerly well entrenched concepts in the management of the disease. These had, over several generations, been so ingrained as to be regarded as the so-called "sacred cows" of Prolonged Rest, Prolonged Isolation and Prolonged Followup.

The author traces the progress of changes that have led to these three being rapidly supplanted by short rest, short isolation and short followup.

THE TERM, "SACRED COW," may be defined as a person, thing, object or idea that has come to be regarded as sacrosanct and therefore, immune from violation, attack or criticism. When anything has been so regarded for nearly 100 years, it is surprising to see its vulnerability exposed. Such is the case with regard to certain aspects of the handling of tuberculosis, and the three sacred cows of Prolonged Rest, Prolonged Isolation and Prolonged (lifetime) Followup are now considered unnecessary.

The basis for this cataclysmic change has been modern chemotherapy. We now have drugs so satisfactory that they have totally changed many of the old concepts of proper handling of the disease. To the diminishing number of us who were forced for years to curse our helplessness while watching so many die from tuberculosis, the new era is especially welcome. We hail it even more than our younger colleagues who have acquired their knowledge and experience with the disease in the sunshine of the chemotherapy age.

The former treatment of tuberculosis, aside from absurd recommendations in vogue at the time for high altitude, dry climate, milk and raw egg diet, horseback riding, outdoor exercise, and the like, began with Edward Livingston Trudeau in 1872. Having been found to have pulmonary tuberculosis, he went to the Adirondack Mountains to spend his last few months in that beautiful area. He survived, to his surprise, and decided that it was because of the rest in bed he had taken. In 1882, he established the Adirondack Cottage Sanatorium at Saranac Lake, New York, for rest-treatment of tuberculosis.

From this humble beginning, sanatorium treatment became the backbone of tuberculosis therapy and the sacred cow, Prolonged Rest, became well established. The concept was broadened to include various methods for decreasing the activity of the lung. Partial collapse of the lung by therapeutic pneumothorax, introduced before the turn of the century, reigned supreme as the ideal treatment for well over half a century. Various surgical procedures basked in their day of popularity. Thorocoplasty was the most common of the major procedures. Many others were used; for instance, extra pleural plombage to compress the lung by the use of foreign bodies introduced into the endothoracic space was one. The foreign bodies utilized ranged from paraffin to plastic sponges, including the use of ping-pong-like balls (briefly at one time). Later, even during the early years of the chemotherapy era lung resection was used extensively. Among the minor surgical pro-

Consultant in Diseases of the Chest, Bureau of Disease Control, Mississippi State Board of Health.

cedures were direct catheter drainage of cavities popularized by Monaldi; closed pneumonolysis to cut adhesions and increase the effectiveness of pneumothorax; and, interruption of the phrenic nerve to paralyze the diaphragm.

All these procedures and others were recognized to be stop-gap at best, but they did save or prolong the lives of thousands. In those days, it was anticipated that sometime, hopefully soon, drugs and antibiotics would be discovered to supplant them. Streptomycin came in 1945 and marked the early dawn of the age of chemotherapy. PAS appeared, and in 1952, Isoniazid, which is still the brightest star in our chemotherapy heavens. Much later, two other major drugs, Ethambutol and Rifampin were added to our armamentarium.

In retrospect, it appears surprising that two decades of modern successful chemotherapy passed before the sacred cow, Prolonged Rest, began to die. However, after almost a century of stressing rest in all its forms, a very rapid change in this direction could not have been expected. The length of time needed for rest in bed was headed downhill at breakneck speed. Only a scant few years ago, it was at least a year; lately, it has paled to a mere two or three weeks, in some instances.

The lack of need for prolonged rest has not been heralded by a large number of reports of carefully conducted investigative efforts in the literature. Rather, it appears as a consensus of experienced observers. There are too many variables to expect anyone to gather a large group of comparable cases. Tuberculogists observed that many individuals, who would not accept rest therapy or who left institutions against advice, did surprisingly well providing they continued chemotherapy. This seemed to hold true even for those who insisted on going back to work long before it was fashionable to allow it.

Gradually, it became apparent that the amount of rest one needs before he can resume his usual occupation, although it needs individualization, is dependent to some degree upon the extent of disease, the rapidity of clearing of symptoms, and the type of work to be done.

Prolonged rest in bed or reduced physical effort is no longer in itself considered of major significance as an aid in the control of the disease. How soon a person will be physically able to do his work, rather than the possibility of whether it will adversely affect his cure, is more in line with the present thought. When faced with the problem of permission for return to work, a physician should, however, call upon restraint and not succumb to any rule of thumb. In any event, the length of time physical rest is demanded has been drastically reduced within the last few years.

Similarly, the sacred cow of Prolonged Isolation is following that of Prolonged Rest to the grave. Isolation as a control measure in infectious diseases has been practiced for millennia.

For many years, we have considered that so long as it were possible to culture tuberculosis organisms from the sputum the individual would be able to transmit the disease. This seemed to be a very logical conclusion and the sacred cow of Prolonged Isolation developed and seemed quite secure.

However, with increasing knowledge of the mode of transmission of tuberculosis and of the effect of chemotherapy, the need for prolonged isolation has been challenged.

To review briefly, the development of the attack on prolonged isolation began in earnest back in 1966. At that time, Kamat[1] in India reported on a carefully conducted study in which a large number of newly diagnosed cases was divided into two groups. Group I was admitted to a sanatorium for one year, immediately upon diagnosis. Group II, similar in all respects to Group I, was treated at home. Both of the two groups were given standard treatment. The only difference between those in Group I and Group II was that the cases in Group II were treated at home in household contact with others. All patients and close contacts of both groups were followed for five years.

According to accepted principles of the time, anyone would have expected that a larger percentage of those in contact with the cases in Group II would become infected and develop disease. Surprisingly, the opposite occurred and 9.4 per cent of the contacts to the home treatment cases developed active disease within five years. Fourteen per cent of the contacts of the sanatorium-treated cases developed active tuberculosis in five years. The difference was not significant enough to indicate an actual danger in isolation but rather that there was no increased benefit in prolonged isolation after chemotherapy was instituted.

Inasmuch as a majority of the secondary cases developed the disease within the first year, and many within the first three months of the study, it became clear that most of the contacts had contracted the infection before treatment of the index case had started. Similarly, a higher percentage of the contacts to sanatorium cases were subsequent tuberculin converters than in those of home treatment cases.

Among more recent studies, Gunnels and associates in 1972[2] and 1974[3] showed that after beginning chemotherapy, no higher risk attended exposure to smear or culture positive cases than was associated with bacteriologically negative patients.

Eddison and Farmer[4] reported that contacts of patients treated with only a short hospitalization did not develop tuberculosis infection more often than contacts of patients kept in the hospital for a prolonged period of time.

The conclusion has become inescapable that once chemotherapy has been started, the chance of transmitting the infection is reduced markedly.

Why is this true? Why would an individual with live *M. tuberculosis* in his sputum transmit the disease only rarely to his household contacts while on adequate chemotherapy? Up to the present time, no one has discovered any change in the organisms themselves. They continue to be indistinguishable from all other *M. tuberculosis* organisms. For the answer one has to recall and marshall several well known facts.

METHODS OF TRANSMISSION

It has been proven, that for all practical purposes, pulmonary tuberculosis is contracted from airborne bacilli. Other methods of transmission occur so rarely as to be of no significance. The droplet nuclei theory was reported by Wells[5] in 1934. Because he did not mention *M. tuberculosis* in his paper, this article did not arouse the attention from tuberculosis that it deserved and was largely overlooked from the tuberculosis transmission standpoint until the work of Riley in 1960,[6] 1961[7] and 1962.[8] He proved conclusively that droplet nuclei bearing the *M. tuberculosis* organism was, by far the major and practically always the only method of spreading tuberculosis from patients to contacts.

Flugge et al,[9] cited in Riley's publication, were the first to point out that droplets from the bronchi, larnyx, nose and mouth containing bacilli are atomized into the air by coughing, sneezing or even talking. The minute amount of liquid in the droplet evaporates rapidly, leaving so-called droplet nuclei to which the bacilli are attached floating in the air, and these are transported by air currents for varying distances. The size of the nuclei depends upon the amount of solid matter in the evaporating droplet. Though nuclei are always much smaller than the droplets themselves, they are larger, compared to the mass of the bacterium, a thousandfold (Wells[5]). If the nuclei are 5 microns or less, they can be inspired through the bronchi into the alveolae of the lung and *M. tuberculosis* may become established. Larger nuclei settle upon the mucous blanket and are expelled from the bronchial tree by ciliary motion.

There is a direct relationship between the numbers of bacilli in the air and the transmission of the disease. It is known that the chance of acquiring an infection by inhalation of the bacilli floating in the air is in direct proportion to the number of bacilli present as shown by Hauk.[9, 10] Therefore, any situation that appreciably reduces the number of bacilli in the air will have a strong bearing on likelihood of acquiring the disease.

To reiterate then, it has been shown that: (1) the infection is acquired from the air; (2) the air has to be seeded with organisms from the patient, principally by coughing; (3) the more organisms in the air, the greater the likelihood of acquiring the infection.

A reduction in cough combined with a reduction in the number of bacilli in the sputum will result in a marked decrease in the ability of the patient to transmit the disease. I.N.H. rapidly accomplishes both by reducing not only cough but also the actual number of bacilli in the sputum. Loudon and Spohn[11] reported a decline of as much as 35 per cent in the frequency of cough in tuberculous cases within the first two weeks of chemotherapy. Yeager, H., et al[13] reported that a rapid fall in the bacterial population of sputum and saliva occurs soon after the institution of chemotherapy. It is felt that after drugs are kept up for a short time the sputum can contain a large enough population of *M. tuberculosis* to scatter a few colonies on the culture medium but, because of dispersion in a vastly larger air volume, the exposed individuals seem to be as safe from the disease as those exposed to a patient with a negative culture. No one would presume to state exactly at what time it is safe to abandon isolation in all cases and specific recommendations cannot be made. There are too many variables.

Some authors have suggested as short a time as two weeks after start of chemotherapy. Certainly one would expect so short a period to be related to an individual with an early minimal lesion.

We must not forget that one of the most important facets of the tuberculosis problem is control of transmission of the disease. The temptation to get the index case back in circulation early must not take precedence over the need to protect those with whom he is in contact.

To prolong isolation of a patient for four to six weeks or longer rather than a mere two weeks and possibly prevent a new case among his contacts must

(Continued on page 319)

Arkansas Internists Meet Nov. 15

Specialists in internal medicine and related medical fields will hold a one-day scientific meeting on Nov. 15, 1975, at the University of Arkansas Medical Center in Little Rock.

Physicians who attend the regional meeting are eligible for credit toward the American Medical Association Physician's Recognition Award in Category #1.

In charge of arrangements for the Arkansas Regional Meeting is Dr. Joseph H. Bates, Little Rock, who serves as the ACP's representative in the state of Arkansas.

Invitation to Scientific Exhibitors

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The Aesculapius Award will be presented to the association member or members having the best scientific exhibit.

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Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

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455

be considered. Each case will have to be judged on its own merits.

By no means the least of these considerations is the reliability of the individual patient. If we rapidly take him out of isolation and allow him to return to his normal life style, will he continue to take the drugs for sufficient length of time? After all, the recent attitudes toward abbreviated rest and isolation are predicated on the assumption that the patient will cooperate in self-medication.

In the past, despite all efforts to stress the importance of long-term medication, one of the greatest problems was compliance on the part of the patient. Perhaps this was because in many cases, tuberculosis even in the early stages is largely asymptomatic. This disinterest has always been prominent. Efforts to convince patients that they were ill did not seem to help. Months of bedrest were prescribed. They were placed in the sanatorium where they observed patients dying with the same disease from which they themselves were suffering. They saw many go through the danger and pain of major surgical procedures. After discharge, continued rest was recommended. Elaborate isolation precautions were to be observed. In spite of all this, an alarming number took the drugs only sporadically or even refused them entirely.

In the present "State of the Art," a patient is not treated as a sick person except for a few short weeks. He is not impressed with the danger of the disease by exposure to long hospital or sanatorium care. Proper "education" of the patient, so impressive in print, in my opinion is not nearly so effective as one might think. Within a few weeks, he feels fine; he has no cough, no fever, no pain and is back at work. Can we expect even a majority of patients to continue self-medication regularly and for a sufficient length of time? Herein lies the principal danger from the recent liberal attitude toward tuberculosis. If the patient, because of lack of fear of the disease, stops medication too soon and reactivates the disease, how much damage will be done to him and his contacts before his condition is discovered? Evidently, a better monitoring method is needed. The computer may be the answer for this is an instance where we need to monitor the monitor so to speak. We must know if the patient has reneged on taking his drugs as soon as possible so that he may be reeducated without delay.

After almost 40 years of handling cases of this disease, I continue to be impressed by the number of patients who truly believe they do not have tuberculosis. When their few, if any, symptoms clear as rapidly as happens under chemotherapy, the individual easily persuades himself that he was correct in assuming that he does not have tuberculosis at all. Prolonged self-medication in such instances becomes progressively more difficult.

Before chemotherapy, the sacred cow of Prolonged Followup became established and has survived for generations. The premise was to follow tuberculosis patients regularly and frequently by x-ray and/or clinic visits in order to detect reactivated disease fairly early in its course. In this way treatment would begin without delay and would, therefore, offer better chance for successful therapy for the patient as well as reduce spread among contacts.

REACTIVATION CONSIDERATIONS

In the days before modern therapy, this was a justifiable procedure. Grzybowski reviewed 450 persons with tuberculosis who had achieved inactive status without chemotherapy and found an astounding 5 per cent reactivation rate every year for 5 years. This means that the disease was reactivated in 25 per cent of these people within five years.

In comparison he found that patients who had "good" chemotherapy experienced a reactivation rate of 0.8 per cent in a 1 to 10 year period of observation. Those patients who received "poor" chemotherapy had a rate midway between those with no chemotherapy and "good" chemotherapy.

Later figures by Stead and Jurgins[14] showed that of 372 patients observed for 3 years after a "good" chemotherapy course, there were only 3 reactivations, giving a rate of 0.012 per cent per year. In comparison 28 patients who received less than "good" chemotherapy experienced a rate of 18 per cent.

Johnson and Wildrick[15] in their excellent "State of the Art" review pointed out that the true value of prolonged followup could be assessed by considering: (1) How many adequately treated patients can be expected to reactivate? (2) Can patients more likely to reactivate be identified? (3) How important are routine clinic followup visits in the diagnosis of reactivations?

It has been shown that the number of cases reactivating following even "poor" chemotherapy are relatively few when the total number of cases is considered. Those following "good" chemotherapy are so sparse that it would require repeated clinic visits and/or x-rays of a very large number of patients in order to discover one reactivation. The importance of the single case is not to be minimized but the enormity of the case load must be considered.

Fortunately, we are not without recourse. Certain known risk factors enable us to reduce the problem to manageable terms.

Edsall and Collins[16] in New York and Bailey and Thompson[17] in New Orleans as quoted by Johnson and Wildrick[15] showed that the rate of reactivation among certain groups was much greater than in others and cited the following ones:

1. Those having had inadequate drug therapy;
2. Alcoholics;
3. Those showing poor cooperation with therapy;
4. Those exhibiting drug toxicity or the presence of resistant organisms;
5. Those with other significant disease.
6. Pregnancy.

If, in a group of patients who have become inactive, we concentrate our efforts on those who belong in one or more of these six groups, we will find practically all of the reactivations. In addition, there is another important factor in our favor.

Most reactivation cases are found when they appear uninvited at the followup clinics complaining of symptoms of chest disease. Edsall and Collins[16] also found that out of between 200 and 250 reactivations, only between 70 and 80 were found by routine x-ray and clinic followup. All the others came in voluntarily because of symptoms. Therefore, if we routinely follow only those who are included in the six risk groups and make certain that all inactive cases are well aware of the symptoms of reactivation and are urged to come in for attention should these symptoms appear, we will have an excellent chance to uncover almost all reactivations.

In the overall picture of tuberculosis control, to be relieved of the expense and professional personnel time in sifting through large flocks of inactive cases will provide more time and money in the fertile fields of chemotherapy, chemoprophylaxis, education and others. ★★★

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October 1975—Immunization Action Month

Carcinoma of the Penis

JOHN P. ELLIOTT, JR., M.D., JAMES O. GORDON, M.D.,
JOHN W. EVANS, M.D., and LUCAS O. PLATT, M.D.
Tupelo, Mississippi

The authors summarize the cases of 11 patients with penile carcinoma whom they saw between December 1964 and December 1973. They discuss the etiology, epidemiology, history of therapy, and present plan of management for patients presenting with carcinoma of the penis.

In a 9-year period from December 1964 through December 1973, 11 patients with squamous cell carcinoma of the penis were treated at the North Mississippi Medical Center. Details of the management of these patients are presented in Table I and the results are summarized as follows: 6 survivors are alive from 21 months to 10 years, 3 patients died of metastasis (all having positive lymph nodes at the time of lymph node dissections), 2 patients died of stroke without any evidence of metastasis.

All malignancies were squamous cell carcinoma. It might be noted that penile amputation may be carried out under local anesthesia without difficulty as long as the lesion can be removed with a 2 cm free margin at the base. Of the 3 poor risk patients who were operated on under local anesthesia, 2 are alive at 10 years and 1 died of stroke 2 months postoperatively.

These results seem to parallel the experience of the Massachusetts General Hospital group, who reported 34 cases during a 15-year period with a 59 per cent survival after 5 years and a 76 per cent overall survival counting those who died of other diseases without known metastasis.[1] They reported a 50 per cent survival of patients with histiologic evidence of lymph node metastasis whereas none of our 3 patients with lymph node metastasis has survived.

Epidemiology. Carcinoma of the penis is a relatively uncommon disease in the United States counting for less than 1 per cent of male malignancies. On the European Continent, however, the incidence is approximately 5 per cent and in China, Puerto Rico, and Jamaica, this malignancy accounts for 18 to 20 per cent of cancers in men.[1]

Etiology. Poor hygiene is probably the largest contributing factor. This factor is of particular importance in the uncircumcised. This is aptly demonstrated by the relatively uncommon occurrence of cancer of the penis in the Jewish male. In the world literature there are only 4 cases in Jewish men and only 3 proven cases in other men who were circumcised in infancy.[1]

There is a natural experiment in India where the Jews and a few Christians are circumcised within a few days of birth.[2] The Moslems circumcise their children at puberty while most Christian and Hindus are never circumcised. Among the males circumcised at birth, penile carcinoma is a rarity. For those circumcised at puberty, an incidence of 5 per cent has been reported, and for those who are uncircumcised, there is an incidence of 15 to 18 per cent.

Causative Agent. Smegma, a substance derived from the desquamation of epithelial surfaces and bacterial action, has been incriminated as the source of carcinogens responsible for penile malignancy.[2] Chronic irritation and infection may also play a role. In support of this, Plant and Kohn-Speyer reported an experiment regarding the use of exposure of mice to smegma and cerumen (a skin product which has never been known to be associated with carcinoma). In the smegma-treated mice, there were multiple tumors compared to the control mice exposed only to cerumen.

History of therapy. Thiersch is credited with having formed the first operation for radical cure of carcinoma of the penis in 1875.[1] In 1907, Young advocated radical penectomy with in-block bilateral lymph node dissection, modified in 1931 to a partial penectomy plus node dissection. In 1948, Daseler plotted the exact distribution of all inguinal lymph nodes and indicated that the node of Cloquet represented the highest deep inguinal node, and was located at the femoral ring. Later Kuehn and Roberts advocated the extension of node dissection to include external iliac nodes. In 1948, Baronofsky described the technique of transplanting the sartorius muscle

From the Division of Urology, North Mississippi Medical Center, Tupelo, Miss.

TABLE I

CARCINOMA OF PENIS

North Mississippi Medical Center, December 1964-December 1974

Patient	*Procedure*	*Date*	*Results*
E. M.	Partial penectomy, Bilateral groin dissection	12-19-64 1-22-65	Alive and well 10 years
A. B.	Partial penectomy under local anesthesia	3-2-65	Alive and well 9 years
C. E.	Partial penectomy under local anesthesia	4-6-65	Alive and well 9 years
M. T.	Complete penile amputation, bilateral inguinal node dissection	5-27-66	Died 2 months post-op of metastasis
L. G.	Complete penectomy	11-16-68	Alive and well 6 years
J. W.	Partial penectomy under local anesthesia	12-23-68	Died with stroke 2 months post-op, no metastasis
H. K.	Complete penectomy and bilateral inguinal node dissection	8-12-69	Died 10 months post-op of metastasis
G. B.	Complete penectomy	6-11-70	Died of stroke, August 1971 without metastasis
R. R.	Complete penectomy with bilateral groin dissection	7-27-71	Died 1 year of metastasis
W. S.	Complete penectomy	12-18-72	Alive and well 18 months
J. K.	Complete penectomy	3-15-73	Alive and well 15 months

over the femoral artery and vein in an effort to protect against catastrophic erosion into the exposed femoral artery.

Present therapy. In 1972, Skinner, Ledbetter, and Kelley gave their experiences utilizing partial penectomies without node dissections. They rationalized that patients with disease in the lymph nodes have no decrease in survival from delayed lymphadenectomy and that if lymphadenectomy were done immediately on all palpable nodes, 50 per cent would be inflammatory. They further outline their plan of therapy as follows:

1. Partial penile amputation, 2 cm proximal to the malignancy.

2. Bilateral inguinal lymph node dissections after a 2-week trial of antibiotics when nodes are palpable, or if they become clinically palpable.

3. When the primary tumor extends to the base of the penis, a radical in-block penectomy together with inguinal and iliac dissection seems indicated.

4. They further recommend transposition of the sartorius muscle to cover the femoral vessels, preservation of Poupart's ligament and suction drainage beneath skin flaps with post-operative immobilization, elevation of the legs and pressure dressing. Because of the immobilization, anticoagulation therapy is recommended with Coumidin on the second postoperative day until the sixth week.

SUMMARY

Eleven patients with carcinoma of the penis are presented with a discussion of the etiology, epidemiology, history of therapy, and present plan of management.

★★★

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A VIEW OF THE FEDS

"The federal bureaucracy has become like the third curse of Moses—a suffocating plague of frogs, brought forth from out of where they belong into the villages and the very houses of the people."

—Former Senator Sam J. Ervin, Jr.

Radiologic Seminar CLV: The Page Kidney: An Unusual Cause of Hypertension

CLIFTON L. HESTER, JR., M.D.
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THE "PAGE KIDNEY" refers to compression of the renal parenchyma to such an extent as to cause decreased renal blood flow, renal ischemia, with elevated renin excretion and arterial hypertension. This is an unusual cause of renal vascular hypertension, but as a highly curable lesion, it should be familiar to all physicians who evaluate the hypertensive patient, especially the urologist and radiologist.[3, 6, 8]

In 1939 Dr. Irving Page published the experimental production of hypertension by renal compression in dogs.[9] Since that time a number of cases of hypertension secondary to severe renal compression have been reported.[1, 3, 5, 6, 8] The kidney in this type of renovascular hypertension is now termed the "Page kidney," just as the usual ischemic kidney in renal artery stenosis is referred to as the "Goldblatt kidney" in honor of the man who first described that entity in 1934.[2]

The usual cause of the "Page kidney" is subcapsular hematoma which may be acute or chronic. Most are secondary to trauma or suspected trauma, but may occur spontaneously. Rare and somewhat questionable cases have been attributed to severe perirenal fibrosis or perirenal hematomas. Subcapsular hematomas that present acutely may be associated with non-function of the involved kidney and are often responsive to conservative management or evacuation of the clot.[4, 7]

The chronic subcapsular hematoma is the most common reported cause of the "Page kidney" and may or may not be calcified. Almost all of the calcified subcapsular hematomas have been in young adult men with a history of playing contact sports, usually football, often with no definite history of renal trauma or hematuria. The diagnosis should be suspected with this history and a calcified mass which on IVP shows normal renal function but with deformity of the calyceal system. High dose urography or nephrotomography will reveal a mass compressing the renal parenchyma. The differential diagnosis would have to include calcified renal cyst, carcinoma, and hamartoma.

The angiographic appearance is diagnostic with: (1) An avascular mass producing marked compression of the renal parenchyma. (2) Absence of neovascularity, AV shunting, or abnormal veins that



Figure 1. The scout film for an excretory urogram reveals a large calcified mass involving the mid portion of the left kidney. This appearance is typical of a calcified subcapsular hematoma. Included in the differential diagnosis would be calcified renal cyst, hematoma, and calcified carcinoma.

Sponsored by Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Hospital, Jackson, Miss.



Figure 2. Infusion pyelogram reveals gross deformity of the collecting system of the left kidney by the large calcified mass.

are seen in neoplasms. This absence should be confirmed by selective angiograms after administration of Priscoline and Epinephrine into the renal artery.

(3) Displacement of the capsular artery by a mass with frequent demonstration of the displaced capsule as a "rim." Because a few cases of peripheral renal cell carcinomas have bled producing acute subcapsular hematoma, it is urged that selective injection



Figure 3. Selective renal arteriogram reveals displacement of vessels with no evidence of neovascularity during an arterial phase.



Figure 4. Magnification view of the capillary phase after Priscoline administration. Compression of the functioning renal kidney is demonstrated on this view. Again there is no evidence of neovascularity.

into the renal artery after drug administration be routinely used in cases of any renal or perirenal mass. In cases where renal vein renin studies were done, all were positive except one on the side of the "Page kidney."

As referred to above, the post-surgical course in patients with hypertension due to renal compression has been either marked improvement in the hypertension or complete return to the normotensive status in all reported cases. ★★★

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MEMBERSHIP MEMO

Theodore Roosevelt said: "Every man owes a part of his time and money to the business or industry in which he is engaged. No man has a moral right to withhold his support from an organization that is striving to improve conditions within his sphere."

—July 1975 ACOG *Newsletter*

An Introduction to the Development of Screening Criteria for the Mississippi Professional Standards Review Organization

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and OREN RENICK, M.P.H.**
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THIS IS THE first of a series of articles to be published in the JOURNAL to acquaint Mississippi physicians with the current status and progress of the Professional Standards Review Organization (PSRO) in this state. This article deals with the work of the Professional Standards Committee of the Mississippi Foundation for Medical Care. The committee is responsible for directing the development of short-stay hospital screening criteria which supports the foundation's concurrent review process being implemented in Mississippi hospitals.

Standards Committee activity stems from its initial meeting at the Mississippi State Medical Association headquarters in November 1974. At that time, the committee was composed of eight physicians with Dr. M. S. Costilow of North Carrollton as chairman. Other original committee members were Drs. J. P. Culpepper, III, Hattiesburg; Carl G. Evers, Jackson; Richard C. Miller, Jackson; Tom H. Mitchell, Vicksburg; Kenneth P. Pittman, Jackson; James W. Rayner, Oxford; and Joe M. Ross, Jr., Vicksburg.

As a result of the first meeting, some basic decisions were made which have been fundamental to the development of criteria:

- based on available information, criteria would be developed first for diagnoses identified as high frequency in Mississippi;
- multispecialty, rather than strictly specialty, panels of physicians from throughout the state would be utilized to review draft criteria;
- effort would be made to collect all available criteria developed by national specialty societies and other physician groups;
- criteria resource materials, including criteria developed by the Mississippi EMCRO program, would be used by foundation staff, primarily R.N.'s, to develop working draft criteria sets for review by physician panels;
- Standards Committee members would work with foundation staff to improve working draft criteria, moderate panel meetings to facilitate review, make general decisions to assure the consistency and simplicity of the criteria;
- Standards Committee members would be responsible for resolving all medical questions which come to light from the review process, which are referred by the physician panels, or which differ from previous decisions made by the committee.

The use of multispecialty panels instead of specialty panels represents a somewhat unique approach in criteria development. The Standards Committee concluded that the physician who typically sees a patient with a particular condition should be represented on the panels. For this reason, a family physician has been included on virtually all panels.

DEVELOPMENT OF CRITERIA

Given the basic decisions of the Standards Committee regarding criteria development, the steps in the criteria review process can be seen. They are:

- selecting (by Standards Committee, physician panel, review process determination, etc.) a diagnosis or problem which requires specific criteria due to its severity, incidence, or which logically should be included in the criteria;
- developing (by foundation staff R.N.'s) a working draft criteria set based on available criteria resource material with physician input (primarily by Standards Committee or specialist consultant) where medical judgments are required;
- circulation of draft criteria sets to physicians on appropriate multi-disciplinary criteria review panel along with resource material and Standards Committee instructions;
- convening panel to review draft criteria sets and

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to reach a consensus within parameters established by the Standards Committee;
- rewriting criteria sets to conform to panel determinations and circulating rewrite to panelists for final review and approval;
- circulation of new criteria sets.

With the circulation of the new criteria set, the crucial test of time begins. Will the set hold up under the scrutiny of the review process? Whether or not this is the case, the criteria set will be evaluated on a semi-annual or as needed basis for refinement or referral back to the Standards Committee or the review panel. Such periodic review is in recognition of the need for on-going evaluation to improve existing criteria sets.

CURRENT STATUS

Following extensive Standards Committee work with draft criteria materials and the establishment of review guidelines, 8 of the 16 multispecialty criteria review panels were convened during April and May 1975 with committee members serving as moderator. These panels reviewed criteria for approximately 90 diagnoses or problems. This effort resulted in the MFMC/PSRO tentative criteria issuance of June 28, 1975. It is being used by review coordinators as screening criteria in every hospital instituting the concurrent review process.

The Standards Committee has been expanded to 11 members. Drs. Culpepper and Rayner have found it necessary to resign from the committee while Drs. George L. Arrington, Meridian; Kenneth R. Bennett, Jackson; Ralph L. Brock, McComb; F. L. Lummus, Tupelo, and Charles E. Sledge, Whitfield, have accepted membership.

The committee has continued to work toward refining existing criteria sets and special listings; initiated its work in resolving problems identified with Professional Activity Study length of stay assignments; and directed the development of additional complete draft criteria sets and the convening of necessary panels.

FUTURE PLANS

The Standards Committee envisions from 150 to 200 complete sets and is working toward that end. It has begun its work of improving and refining existing criteria. Finally, the committee will always strive to move closer to its goal of the development of statewide criteria that accurately represent medical practice as it actually occurs throughout all areas of Mississippi.

Next month the article will cover the tentative criteria manual as a whole. ★★★

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CAN BEETHOVEN'S 9TH CURE HERNIA?

Classical music is being played in parts of Europe for medicinal purposes, says the Health Insurance Institute.

The melodies, played through a device developed by Guy Allaire of France, breaks down cell tissue by transforming the sounds into direct vibrations.

The patient listens through earphones while the tunes are further relayed through electrodes attached to the body.

In Rome, surgeon Geotano Zappalo has been using Bach fugues to treat indigestion.

It has also been found that Mozart is an ideal choice when tackling rheumatism; Handel helps "broken hearts" and other disturbed emotional states.

What about Beethoven? He's considered good for hernia.

And Schubert? His music is doing what many classical musical haters claim this type of music has done for them for years—it's being used to cure the problem of insomnia.

Health Insurance News



The President Speaking

"Malpractice Solutions"

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

THERE IS LITTLE wonder that professional liability insurance and the so called medical malpractice crisis are foremost in the minds of Mississippi physicians at this time. Only one insurance company in the state is continuing to write new professional liability coverage. The St. Paul Fire and Marine Insurance Company currently covers approximately 94 per cent of the physicians in Mississippi for professional liability. Officials of the St. Paul Company have flatly stated that if they cannot make a profit on the malpractice insurance business then they will get out of the market. In view of the fact that the company lost over seven million dollars on this line of business last year it is questionable whether they will indeed be able to make a profit in the future. Our concern is assuring that malpractice insurance will always be available for the physicians in Mississippi at the lowest cost possible.

In the face of this dilemma what do we, the practitioners of medicine, propose as a solution? In the first place your House of Delegates will meet in a special session in Jackson on Oct. 23, 1975, to consider the advisability of establishing a self-insured program of professional liability insurance for Mississippi State Medical Association members. Secondly your state association will actively work for enactment of legislation, in the next session of our legislature, to stabilize the professional liability insurance market.

In our system of government, proposed legislation becomes law by a variety of techniques: (1) Public persuasion in which we help the citizens of our state understand that they have a stake in the issue of medical liability insurance. (2) Lobbying in which we join other groups such as management, labor, consumer groups, attorneys and any other groups with whom we agree, and seek to convince the legislature and the governor that our view is the best possible solution for our state. (3) Electioneering in which we actually support those candidates who see the issue as we see it and actively oppose those who do not.

I am encouraged by a recent meeting with representatives of the Mississippi Bar Association who tell us that they not only agree but are willing to assist us in seeking enactment of legislation relating to lowering the statute of limitations in Mississippi, establishment of screening panels to eliminate non-meritorious litigation, and other measures aimed at stabilizing the malpractice problem in our state.

I urge each of you to familiarize yourself with the problems we face and the solutions we propose. Instruct your Delegates prior to the special session of Oct. 23, and become actively involved in the decision making process. These are critical issues that deserve mature and careful consideration. ★★★

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EDITORIALS

Disincentives to Practice

Medicare fee data gathered by the National Planning Association from other states and compared with Medicare fee data in Mississippi indicates a wide divergence of fees between urban and rural areas—and even between states within these areas.

The NPA quotes fees for urban and rural areas in three states—New Jersey, North Carolina and Georgia; Medicare and Medicaid fees in Mississippi for fiscal year 1975 have been added for purposes of comparison. See table below.

The NPA reports that third-party payment schedules, particularly those for Medicare and Medicaid, create "disincentives to practice in areas already deficient in health services." If the present federally accepted concept of prevailing fees for a given service in a given area is carried over into a national health insurance system, "results for rural people could be disastrous," the NPA concludes.

In Mississippi, a heavily rural state, where physicians are presently caring for about twice as many patients as the national average, Medicare and Medicaid payment schedules are definite disincentives to practice in the state.

CHARLES L. MATHEWS
Executive Secretary

Medico-Legal Briefs

PHYSICIAN NOT LIABLE FOR FAILING TO INFORM HOSPITAL OF HIS ABSENCE

A physician was not liable for a patient's injuries when he failed to inform a hospital that he would be absent on the date the patient entered the hospital for treatment of injuries suffered in an accident, a Texas appellate court ruled.

The patient was injured in an automobile accident and admitted to the hospital. He was treated by an emergency room physician. The patient's own physician, who was on the staff of the hospital, had been called out of town earlier in the day.

The emergency room physician was one of a group of physicians from a nearby naval base who took over the emergency room duties at the hospital on week-ends. Each member of the hospital staff contributed to a fund from which the hospital paid the "moonlighting" naval physicians. The hospital administrator considered them to be employees of the staff physicians, and he did not withhold social security or income taxes from their pay.

In a malpractice suit against his physician, the patient contended that he was liable for the negli-

	New Jersey Medicare		*North Carolina Medicare*		*Georgia Medicare*		*Mississippi Medicare*		*Mississippi Medicaid*
	NORTHERN	SOUTHERN	URBAN	RURAL	URBAN	RURAL	URBAN	RURAL	
Colles fracture	$175	$125	$150	$125	$150	$100	$150	$125	$ 70
Pacemaker	850	500	800	600	——	——	500	500	300
Gastroscopy	150	100	125	120	75	100	125	100	55
Cholecystectomy	525	450	420	375	435	400	400	350	300
Hernia—unilateral	350	275	250	245	275	250	250	225	150
D&C	160	150	105	100	150	100	125	100	30
Hysterectomy	630	450	500	420	500	450	400	350	250
GI series	55	45	36	30	35	35	35	35	28
Orchiectomy	350	200	205	205	200	300	150	——	105

gence of the emergency room physician, for failing to inform the hospital that he would be unavailable, and for failing to provide adequate personnel to treat his patients. A trial court granted a summary judgment motion in favor of the physician, and the patient appealed.

On appeal, the appellate court said first that the physician clearly had no control over the work of the naval physician working in the emergency room. In the absence of any control over him, the patient's physician could not be liable for his acts, the court said.

Moreover, there was no negligence on the part of the patient's physician in failing to inform his answering service or the hospital of his absence. At the time the physician left town, the patient was not under his care. The patient was admitted to the hospital after the accident under the care of the physician, but the patient had not seen him for any kind of treatment during the year.

Area physicians had established definite procedures for insuring that patients would be admitted to the hospital even when the physician of the patient's choice could not be located. Since arrangements for adequate medical attention for patients had been made, there was no negligence in the physician's failure to inform the hospital of his absence. He had discharged his duty to ensure that competent medical help was available to his patients.—*Sendjar v. Gonzalez,* 520 S.W.2d 478 (Tex.Ct. of Civil App., Feb. 26, 1975)

Eastland Praises Family Practitioner

In a speech on "Dr. Earl Laird Day" in Union, Mississippi, Senior Senator James O. Eastland has praised the tradition of the rural family doctor in Mississippi.

Speaking to a large and enthusiastic crowd of "Dr. Earl's" friends and patients, Senator Eastland said, "The aim of all medical legislation—on the state as well as the national level—is to achieve one thing: The assurance that the people of all the hundreds of small communities throughout this nation continue to receive the best that modern medical science has to offer."

Eastland praised the concept of the family practitioner, the "family doctor."

"The family doctor represents a brand of service and dedication that is rare, but at the same time, is an idea that is catching fire with our young people in medical schools today."

"For many years we witnessed a movement toward specialization in medical schools. And this specialization led to medical services being centered in larger cities."

"I am happy to say that now the tide is shifting back to family practice. Our medical schools, doctors, and students have realized that the family doctor is the cornerstone of the medical delivery system. He is more than a technician or scientist—he is our friend and counselor."

Eastland said this realization of the importance of the family physician has led to an increased drive to train more physicians to serve in small communities.

"In 1971, our own legislature created a Department of Family Practice at the University of Mississippi Medical School," said Eastland.

MPAC Has Impact

The Mississippi Medical Political Action Committee took its first step into state legislative races this year and prior to the November General Elections, MPAC was batting 76 per cent.

Going through a process of determining local medical interest and support of candidates and examining "The Health Voting Index" of incumbents, MPAC supported both challengers and incumbents in Mississippi House and Senate races throughout the state in the First and Second Primaries.

MPAC's membership is composed of physicians and their spouses. The PAC is committed to local political education and support of political candidates. Prior to this year, the PAC had only been involved in Congressional elections.

NEW MEMBERS

STEIGER, EZRA, Pascagoula. Born Cleveland, Ohio, June 4, 1941; M.D., Ohio State University College of Medicine, Columbus, Ohio, 1966; interned Hospital of University of Pennsylvania, one year; residency (surgery), same, 1967-73; elected by Singing River Medical Society.

DEATHS

BENNETT, HACKETT, Meridian. Born Meridian, Miss., May 11, 1912; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1942; interned Charity Hospital, Shreveport, La., one year; died Aug. 19, 1975, age 63.

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The William Mason (1856)

School of Medicine Enrolls Over 500

More than 500 students enrolled this fall at the University of Mississippi School of Medicine, the largest number in the 20-year history of the Medical Center.

Anticipated enrollment was set at 531 for the medical school, an increase of 41 over last year's fall quarter enrollment. Final figures were not available at press time.

The 151-member freshman class was expected to help push total Medical Center enrollment to nearly 1,300. The state's first dental student class, students in the two-year upper division School of Nursing curriculum, and those in the School of Health Related Professions registered with medical students. Others studying at UMC this year include those in the graduate program and in nurse-midwifery, family health nurse associate, and perinatal nurse clinician educational programs.

Blues Are Criticized in Government Study

A yet unpublished government study has criticized Blue Cross-Blue Shield management which handles almost half the nation's private health insurance business and processes 90 per cent of Medicare claims.

The study, which was commissioned by the Social Security Administration, found that the large, profit making insurance companies are more efficient than either the government or Blue Cross-Blue Shield in administering health benefit plans.

"Blue Cross-Blue Shield have not taken advantage of potential economies of scale (size) to reduce the cost of health insurance. Instead they have dissipated the potential savings in increased administrative costs," the study said.

The study's findings are viewed as important for any national health insurance plan. One of the issues in structuring a national health plan has been who shall run it—the government, the non-profit insurance organizations such as the Blues, or the profit making, commercial health insurance industry.

The study's authors—Ronald J. Vogel, an economist with the SSA's Office of Research and Statistics, which commissioned the study, and Roger D. Blair of the University of Florida conclude that on efficiency grounds their findings of economy of scale for commercial insurers indicate that health insurance ought to be somewhat centralized in the hands of large, competitive firms.

LETTERS

SIRS: The Mississippi State Board of Health's hypertension control program is able to offer physicians two areas of referral service for the care and treatment of hypertensive patients. They are joint management and total management.

In the *joint management* of the hypertensive patient, the physician referring the patient should indicate what services he is requesting. (Example: medical examination, lab work, nursing services, EKG, etc.). The health department will provide all services requested and forward the reports to the referring physician.

Patients seen under the terms of this joint management system will be placed on the state hypertension register. Patients on this register are required to have at least one blood pressure check per month at the county health department. If two consecutive monthly visits are missed, the health department will make contact to encourage compliance through counseling. We will furnish any of our available services, including drugs, if desired. Under the provisions of our grant we will undertake to see that third party funds for services and drugs are used effectively. Nothing in the present program, however, is intended to impose any conditions which would require charges for services to people unable to pay, nor to provide revenue for the health department. This means, for example, that any patient receiving Medicaid benefits or funds from any other third party source, will be given a prescription for his drugs in order that these may be obtained from the pharmacy of his choice.

In *total management* of the hypertensive patient, the health department will assume complete responsibility for evaluation, diagnosis and monthly surveillance.

These services are offered for hypertensive patients: Lab Tests: AA3 (Cholesterol, Creatinine, Uric Acid); Coulter (CBC, Blood indices); Electrolytes (except C02); Glucose; Urinalysis by multistix. Other services include: Medical Examination, EKG; Chest X-Ray; Drugs; Monthly blood pressure check.

DURWARD BLAKEY, M.D., Chief
Bureau of Disease Control

Book Reviews

Review of Medical Physiology. 7th edition. By William F. Ganong, M.D. 587 pages with illustrations. Los Altos: Lange Medical Publications, 1975. $10.50.

Dr. Ganong has written a clear, short and clinically oriented textbook of physiology. In all areas where I profess to be expert he has done an excellent job in describing the basic physiology. The chapters in areas where I am ignorant are clear, and if they are equally correct, those chapters should give me an excellent opportunity to increase my knowledge. Dr. Ganong's personal studies have been especially related to the central nervous system, control of endocrine function, and to endocrine control of electrolyte balance. These chapters are especially clear.

I would fault the text in its lack of emphasis on the integration of the various functions required to maintain homeostasis. His description of hypertension, oddly enough, misses completely the opportunity to discuss the mechanisms by which the various experimental models for clinical syndromes produce hypertension.

The medical student will find this a simple and clear text that should give him most of the information that he needs. It should be also of value for the graduate physician who wishes to review basic physiology without too much pain.

HERBERT G. LANGFORD, M.D.
Jackson, Miss.

Obstetrics and Gynecology. 5th Edition. By J. R. Willson, M.D., C. T. Beecham, M.D., and E. R. Carrington, M.D., 698 pages with 558 illustrations, bibliographies and index. St. Louis: The C. V. Mosby Company, 1975. $22.50.

In 1959 when I was a junior medical student and having my first exposure to obstetrics and gynecology, I acquired a copy of the first edition of Willson's *Obstetrics and Gynecology* because it was one of the smaller books on the subject available. It turned out to be one of the easiest read and understood texts I've ever had the pleasure of reading. The precise and interesting way in which it was written made the subject of obstetrics and gynecology far more interesting than I thought it could be at that time.

The fifth edition has retained these attributes and has expanded to include the important advances in our specialty in the past 17 years. Two of the outstanding sections in this book are the chapter on psychology and life periods of women; sections of which are almost tenderly written, and the chapter on gynecologic cancer which is concise, well organized, and easily understood. The rather complicated subject of ovarian tumors follows the excellent classification of Abell.

If there is any criticism of this book, it would be with the brevity with which some of the important advances in gynecology such as colposcopy and cryosurgery are treated. In contrast, a full page is devoted to a diet which lists some 31 vegetables and 21 fruits including dandelion greens, endives, kale, romaine, and huckleberries.

For the stated purpose of providing a basic text for the medical student, family physician and physicians in specialties other than obstetrics and gynecology, it does a beautiful job. With many illustrations, graphs and tables, it also supplies the specialist with a quick concise source of organized information.

MELVIN R. HOLMAN, M.D.
Amory, Miss.

PERSONALS

GEORGE L. ARRINGTON of Meridian announces the association of ROBERT J. CATER for the practice of otolaryngology and maxillofacial and facial plastic surgery at 1413 22nd Avenue.

S. LAMAR BAILEY was inducted into the MSMA Fifty Year Club at a special ceremony at Montfort Jones Memorial Hospital. STANLEY HARTNESS of Kosciusko, president of the North Central District Medical Society, made the presentation of the certificate and lapel button signifying membership.

LUIS BORRELL has associated with the Rush Medical Group of Meridian at 1314 19th Avenue for the practice of internal medicine and pulmonary diseases.

PERSONALS / Continued

JOHN W. BOWLIN of Tupelo announces the association of FRANK A. NICHOLS for the practice of cardiovascular and thoracic surgery at 810 Garfield Street.

WILLIAM E. CALVERT announces the opening of his office for the practice of medicine and surgery at 304 N. Second Street in Bay St. Louis.

EDWARD H. CURRIE of Gulfport is serving as chairman of the Professional Division of the fall United Way Campaign in the Gulfport Area.

WARREN B. DALE of Lumberton was honored with a special Dr. Warren B. Dale Day in Lumberton in recognition of his practice there for the past 18 years.

MARSHALL STONE ELLIS announces the opening of his office for the practice of family medicine at Highway 78 East in Holly Springs.

MICHAEL FOOSE announces the opening of his office for the practice of family medicine at 718 E. 15th Street in Yazoo City.

JOHN Y. GIBSON of Jackson and UMC took a diagnostic ultrasound training course in Philadelphia, Pa., Aug. 1-30.

ROBERT M. GRAHAM of Meridian announces the association of ROBERT E. DILWORTH for the practice of urology at 1302 20th Avenue.

GEORGE C. HAMILTON, JR., and WILLIAM C. MCQUINN of Jackson announce the relocation of offices for the practice of psychiatry to 1040 Riverside Plaza, East Lakeland Drive.

H. BRAD HEITZMAN of Biloxi announces the removal of his office to 1210 West Division Street.

HERBERT P. KINSEY has associated with DAYTON E. WHITES and THOMAS R. SHAW of Lucedale for the practice of family medicine and general surgery at the Community Medical Center.

EARL LAIRD, SR., of Union was honored with a day of tribute, Sept. 6, by the community to recognize his many years of service.

F. MITCHELL MASSEY has associated with EARL E. WHITWELL and BEN H. BUCHANAN of Tupelo for the practice of orthopaedic surgery at 420 Magazine Street.

JAMES N. MCQUEEN announces the opening of his office for the practice of dermatology at Medical Towers, Suite 604, in Jackson.

CHARLES D. MILES has associated with JOHN N. HARRINGTON and PERRIN N. SMITH of Columbus for the practice of obstetrics and gynecology at The Professional Center, 221 North 7th Street.

EDWARD R. NORTH, JR., of Jackson was elected as a member of the board of directors of the National Exchange Club during its recent convention in Honolulu.

W. W. OLIPHANT has set up practice in the Doctors Clinic of DeKalb with JIM SMITH. Dr. Oliphant is a family practitioner and surgeon.

S. RAY PATE and WILLIAM GILLESPIE of Jackson have moved their offices to 971 Lakeland Drive, Suite 202, for the practice of psychiatry.

PAUL W. PIERCE, III, has associated with The Vicksburg Clinic for the practice of internal medicine.

RICHARD E. RHODEN has been appointed Director of Outpatient Services at the Jackson Mental Health Center.

R. L. THOMPSON has associated with the Boone Clinic in Laurel.

The Vicksburg Clinic announces the association of GENE WARREN in the Department of Radiology.

MSMA/Bar Committee Holds Meeting

A committee composed of representatives of the Mississippi Bar Association and MSMA held a meeting on Aug. 27 to discuss subjects of mutual concern to the two professions. As a result of the meeting, the group appointed a subcommittee to immediately begin to study and recommend solutions to the professional liability insurance crisis. The full committee will meet again in October to consider recommendations from the subcommittee and to begin work on revising the "Mississippi Interprofessional Code for Physicians and Attorneys" formulated by the MBA and MSMA in 1962.

Members of the MSMA/MBA Liaison Committee are: MBA—Curtis L. Coker, Jackson, chairman; Wade Lagrone, Tupelo; Louis G. Baine, Jackson; Ernest Graves, Natchez; Lampton Williams, Poplarville; Dixon L. Pyles, Jackson; Alfred E. Lee, Oxford; MSMA—Jack A. Atkinson, Jackson, chairman; Charles R. Jenkins, Laurel; Martin B. Harthcock, Jr., Jackson; Lyne S. Gamble, Greenville; and George D. Purvis, Jackson.

MSMA Board of Trustees Conducts Annual Summer Meeting at Clarksdale

Following its usual custom of conducting the summer meeting in one of the local component society areas, the MSMA Board of Trustees met in Clarksdale, Aug. 21-22.

Primary business coming before the Board were reports on the professional liability insurance situation in Mississippi, activities of the Mississippi Medical Political Action Committee and referrals from the May meeting of the MSMA House of Delegates dealing with organization of the Board and other councils, physician assistants, chiropractors, Medicare reimbursement and services to component societies.

The Board acted to call a Special Session of the MSMA House of Delegates in Jackson on Oct. 23, 1975, to consider establishment of a non-profit, physician membership corporation to provide professional liability coverage and other appropriate services to its members. Information about the program will be mailed to every MSMA member prior to the special meeting of the House so they may express their views on the program to their delegate(s).

The Board reviewed the status of legal action to enjoin chiropractors from using treatment modalities that violate provisions of the chiropractic licensing act and result in the practice of medicine without a license. Plans now call for the association to file a suit in this regard during the Fall Term of Chancery Court in Hinds County.

The Board also considered the status of association efforts to seek an adjustment in Medicare payments in Mississippi to make them more equitable. Representatives of the association will meet with the AMA Council on Medical Service to discuss this in September.

The Mississippi Medical Political Action Committee reported on its highly successful legislative candidate support actvities during the First Primary Elections.

In other actions, the Board formally expressed its concern to the Mississippi State Board of Health about implementation of requirements for annual registration of physicians' licenses and asked the Mississippi State Board of Nursing to reconsider its recent action limiting the functions of LPNs.

The Board further expressed its opposition to funding of an HMO in Jackson County based on lack of support for the project from local business and professional groups and need for the project. The Board received a report from the Council on Medical Education concerning its survey and directory of continuing medical education programs in Mississippi, and the Council on Scientific Assembly reported on planning for the 108th Annual Session.

Members of the Board are: Drs. James O. Gilmore, Oxford, chairman; Robert S. Caldwell, Tupelo, vice chairman; Gerald P. Gable, Hattiesburg, secretary; Whitman B. Johnson, Jr., Clarksdale; Arthur A. Derrick, Jr., Durant; Joe S. Covington, Meridian; Sidney O. Graves, Jr., Natchez; Paul H. Moore, Pascagoula; Carl G. Evers, Jackson; Max L. Pharr, Jackson; J. T. Davis, Corinth, immediate past president; and Jack A. Atkinson, Brookhaven, president. MSMA Officers sitting with the Board are: Drs. Lyne S. Gamble, Greenville, president-elect; James P. Spell, Jackson, secretary-treasurer; C. D. Taylor, Pass Christian, speaker, House of Delegates; R. Fazer Triplett, Jackson, vice speaker, House of Delegates; Joseph B. Rogers, Biloxi, Delegate to the AMA; and G. Swink Hicks, Natchez, Delegate to the AMA.

POSTGRADUATE CALENDAR

Oct. 21-22, 1975

HEMATOLOGY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinators:
Francis Morrison, M.D., associate professor of medicine, the University of Mississippi School of Medicine
J. Tate Thigpen, M.D., assistant professor of medicine, the University of Mississippi School of Medicine

This two-day course reviews recent advances in the basics of diagnosis and treatment of hematologic disorders. Fee is $50.00.

Oct. 23-24, 1975

ONCOLOGY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinators:
Francis Morrison, M.D., associate professor of medicine, the University of Mississippi School of Medicine
J. Tate Thigpen, M.D., assistant professor of medicine, the University of Mississippi School of Medicine

The two-day course is designed to update the primary care physician in advances in oncology, which now includes the word "cure" for certain neoplasms. Participants will cover the role and principles of chemotherapy and discuss details of handling patients receiving immunosuppressive therapy, with emphasis on side effects. Course fee is $50.00.

Oct. 30-31, 1975

INFECTIOUS DISEASES INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education, with partial support from Mississippi Regional Medical Program

Pediatric Pulmonary Conference Held



Mississippi physicians attending the First LAMOT Pediatric Pulmonary Conference at the Chateau Hotel in Shreveport include (from left) Dr. James M. Packer, Dr. Douglas Parkin, Dr. Suzanne T. Miller, Dr. Robert P. Henderson, all of Jackson, Dr. Louis Lehmann and Dr. John Coffey, Jr., both of Natchez. The Second Annual LAMOT Conference, sponsored by Lung Associations and Thoracic Societies of Louisiana, Alabama, Mississippi, Oklahoma, and Texas, will be held Sept. 17-18, 1976, in Shreveport.

Board of Nursing Stops IVs

The Mississippi Board of Nursing in a decision dated July 8, 1975, has stoped LPNs from administering intracavity fluids and medications. Describing itself as a "Public Consumer Protection Agency," the Board stated that LPNs ". . . have been utilized throughout the state in both hospitals and nursing homes in an expanded role for which they have no formal training and that this improper utilization is not in the best interest of quality patient care. . . ." The Board continued ". . . that any additional formal education for the LPN should be directed at assisting them to become qualified as a RN rather than extending their presently defined role beyond basic preparation."

The Board has been asked to reconsider its decision by both MSMA and the Mississippi Hospital Association. MSMA officially asked the Board to reconsider the decision because of its immediacy and impact on health care delivery in the state. Prior to the Board's decision, the Joint Practice Committee of the Mississippi Nurses Association and MSMA

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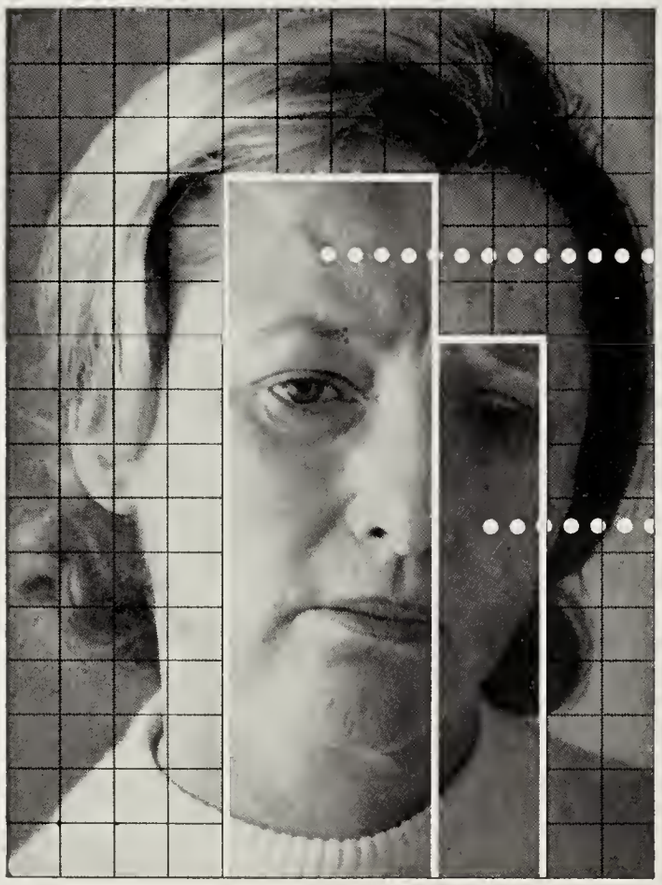
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
November 1975, Vol. XVI, No. 11

ORIGINAL PAPERS

Paraneoplastic Manifestations in Gastric Carcinoma

BILL W. LONG, M.D.,
J. TATE THIGPEN, M.D., and
FRANCIS S. MORRISON, M.D.
Jackson, Mississippi

A case of gastric carcinoma is described. Paraneoplastic manifestations of migratory thrombophlebitis, cryofibrinogenemia, high CEA titer, and elevated non-prostatic acid phosphatase are discussed as to cause and clinical significance. Emphasis is placed on the possible relationship of migratory thrombophlebitis and cryofibrinogenemia to tumor-related chronic intravascular coagulation.

CARCINOMA HAS BEEN associated with numerous manifestations not explainable as direct effects of the neoplasm. These manifestations are collectively designated as paraneoplastic syndromes and may provide clues to the diagnosis of an otherwise occult malignancy. This case report demonstrates an interesting association between four such paraneoplastic effects: migratory thrombophlebitis, cryofibrinogenemia, and elevated CEA titer, and elevated non-prostatic acid phosphatase.

CASE REPORT

A 46-year-old Caucasian man was referred to the Jackson VA Hospital for evaluation of migratory thrombophlebitis involving both upper and lower extremities of three months' duration. Other associated symptoms included a 30-pound weight loss, fever, and episodic chest pain with dyspnea. Evaluation at 2 other institutions during the preceding 3 months included: normal CBC, normal SMA-12 screen, normal urinalysis, normal chest x-ray, normal bone survey, normal upper gastrointestinal series and hypotonic duodenography, normal barium enema, normal cholecystogram, normal IVP, normal pancreatic scan, normal bone scan, and normal EKG. Coagulation studies were normal. Immunologic studies including LE prep, ANA, β-1C levels, and latex were normal. Muscle biopsy and bone marrow examination were normal. Abnormal studies included abnormal right lung perfusion on lung scan, positive cryofibrinogens, and an elevated acid phosphatase. Prostate biopsy was normal. The patient had been maintained on intravenous heparin therapy subsequent to these evaluations to control his thrombophlebitis which relapsed on trial of Warfarin and subcutaneous heparin.

Physical examinations on admission revealed as abnormal findings an elevated temperature of 100 degrees F orally, clubbing of the fingers on both hands, thrombophlebitis of the left calf, and a pleural friction rub on the right.

Laboratory data, including repeats of those studies done previously, again were normal except for an elevated alkaline phosphatase of 30 (normal 10-17), an elevated acid phosphatase of 4.0 (normal 2.2), and a positive test for cryofibrinogen. A CEA sent

From the Division of Hematology-Oncology, Department of Medicine, University of Mississippi School of Medicine, Jackson, Miss.

to Bio-Science subsequently was reported as 95 ng/ml (normal 2.5 ng/ml), and a fractionated acid phosphatase from Bio-Science revealed a total 19.8 I.U. with the prostatic fraction only 0.8 I.U.

Two weeks after admission, the patient noted a right supraclavicular node which on biopsy revealed poorly differentiated carcinoma. Further evaluations for a primary site, including proctoscopy, bronchoscopy, tomograms of the lungs, repeat prostatic biopsy, and brain and liver scans, were negative, as was an α_1-fetoglobulin. Renal and celiac arteriograms were also normal. A lung scan suggested recurrent pulmonary emboli.

The patient was discharged on heparin but returned 3 weeks later with persistent nausea and vomiting, bilateral papilledema, and headaches. Repeat brain scan demonstrated a parietal lesion, and repeat UGI revealed a mass in the cardioesophageal area. Gastroscopy with biopsy confirmed a diagnosis of gastric adenocarcinoma. A few days following this the patient had an episode of massive hemoptysis, developed Cheyne-Stokes respirations, and expired.

Post-mortem examination demonstrated carcinoma of the gastric cardia with metastases to celiac, pancreatic, mesenteric, and mediastinal nodes. Lungs, spleen, kidneys had numerous healed infarcts. The brain revealed tumor cells in the subarachnoid space plus cortical venous thrombosis and infarction without evidence of tumor invasion.

DISCUSSION

This case demonstrates an unusual combination of several less common manifestations of neoplastic disease. Of central interest are the manifestations of migratory thrombophlebitis, cryofibrinogenemia, CEA, and elevated non-prostatic acid phosphatase.

First, thrombophlebitis as a paraneoplastic manifestation was described over 100 years ago by Trousseau.[1] A subsequent review[2] established several pertinent points from a series of 80 cases demonstrating thrombophlebitis and cancer. To begin with, although the incidence of thrombophlebitis may be increased in patients with cancer, patients presenting with *spontaneous* thrombophlebitis have a high incidence of underlying malignancy (15 per cent).[3] Secondly, *migratory* thrombophlebitis involving repeated episodes in both upper and lower extremities is even more suggestive of occult malignancy.[4] Thirdly, tumors most commonly associated with migratory thrombophlebitis were pancreatic carcinoma, particularly of the body and tail, and carcinoma of the lung; other associated tumors included adenocarcinoma of the stomach, ovary, colon, gallbladder, liver and prostate. Our case exemplifies migratory thrombophlebitis associated with adenocarcinoma of the stomach, an infrequently reported association.

Secondly, cryofibrinogens have been reported in a wide variety of diseases but more commonly in association with inflammatory or neoplastic disorders. That this manifestation and migratory thrombophlebitis as seen together in our patient and 2 other cases (carcinomas of lung and ovary)[5, 6] may be related to a common etiology is suggested by data showing a delicately balanced coagulation mechanism in patients with malignancy.[7] Other authors suggest that cryofibrinogens may simply be complexes of circulating fibrin monomer and certain fibrin split products.[5] Thus, both manifestations of cryofibrinogenemia and migratory thrombophlebitis may relate to a chronic intravascular coagulation secondary[8, 9] to slow release of thromboplastic material from the tumor. Confirmation of such a sequence has been difficult because of reports of normal platelet counts and fibrinogen levels plus the absence of fibrin split products in cases having migratory thrombophlebitis associated with neoplasia;[5] such findings may, however, result from the low-grade nature of the intravascular coagulation[10] and rapid R-E clearing of complexes of fibrin monomer and fibrin split products. In the present case, a chronic process of intravascular coagulation resulting from tumor-released thromboplastic material could explain not only the migratory thrombophlebitis and the cryofibrinogenemia but also the splenic, renal, pulmonary, and cerebral infarcts.

Thirdly, this patient demonstrated a very high CEA (carcinoembryonic antigen) titer. CEA, a glycoprotein, is one of 6 oncofetal antigens reported to be present in the blood of patients with various malignancies and also a variety of benign conditions.[11] It, along with alpha-feto-globulin, has undergone extensive investigation to delineate possible applicability to clinical evaluation of patients with gastrointestinal adenocarcinoma. Although present in non-malignant conditions, the titer of CEA appears to be higher in malignancy, with levels > 55 ng/ml (normal 0-12.5 ng/ml) being virtually diagnostic of malignancy;[12] in our patient, the level of 95 ng/ml would therefore be highly significant. That CEA is a paraneoplastic manifestation is convincingly shown by numerous reports of falls in titer with remission and rises with subsequent relapse.[13] It is this last aspect which appears to give the test its greatest clinical relevance as a means of following response to therapy.

Fourthly, acid phosphatase fractionation revealed

a marked and very difficult-to-explain elevation of the non-prostatic acid phosphatase fraction in our case. A number of clinical states have been noted to lead to elevation of acid phosphatase; prostatic carcinoma, Gaucher's disease and other lipoidoses, increased osteoclastic activity, increased platelet turnover, thromboembolic states, myeloproliferative disorders, hyperthyroidism, familial multiple adenomatosis, liver diseases, and a number of malignant neoplasms usually with bone metastases.[14, 15] Certainly the current case demonstrates several of the above-mentioned states, but each one present usually leads only to mild elevations. Marked elevations are seen only in prostatic carcinoma and Gaucher's disease; evidence for neither as an explanation for the markedly elevated acid phosphatase in this case is present. Thus, this aspect of the current case remains an enigma.

SUMMARY

This case illustrates four of a wide variety of paraneoplastic syndromes. The value of these phenomena to the clinician is that they provide clues to diagnosis of occult carcinoma, but infrequently at a curable stage of disease. Commonly, these manifestations are confusing when considered as isolated occurrences. However, when the diagnosis of an occult malignancy is entertained, this provides a uniform etiologic explanation for these paraneoplastic syndromes. ★★★

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Hypospadias: A General Review

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HYPOSPADIAS (Gr. *hypo* under + *spadon* a rent) is one of the more common urogenital anomalies. It represents a congenital abnormality in which the urethra terminates in an abnormal position. The opening can be anywhere along the midline of the ventral surface of the penis between the normal site and the perineum. The disorder is usually associated with some degree of chordee (L. *chorda* string) which is manifested by ventral curvature of the penis. If chordee is present, it is more easily recognized during an erection. The prepuce is hooded; that is, there is an abundance of foreskin dorsally and laterally and a deficiency ventrally (see Figures 1 and 2).

Hormones, mainly testosterone, secreted by the developing testes, cause the external genitalia to assume the normal male appearance (see Figure 3). Without these hormones, the external genitalia would develop into a normal female configuration. At about 10 weeks of life the genital tubercle grows and takes on the appearance of a penis. During the next four weeks, as the penis enlarges, a groove develops on the ventral surface of the penis. The edges of the urogenital groove fold together and unite distally toward the glans penis. This is an epithelial plate which divides the glans penis into right and left halves. By a combination of external trough formation and hollowing, the plate produces a tube with the opening at the tip of the glans penis.[1]

Hypospadias is failure of proper closure of the urethral groove. At this time, it is uncertain what causes this improper closure. It has been suggested that early administration of progestrin to the mother might cause hypospadias by decreasing the level of gonadotrophin.[2] A significant increase of testicular anomalies has been found in the fathers of hypospadiac males along with an increased incidence in premature males. There has been no definite genetic causative factor found; however, there is an increased familial incidence.[3]

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The overall incidence of hypospadias in the general male population is about one in every 300 to 400 boys.[4] There were 22,778 boys born in Mississippi in 1973; therefore, there should have been about 56 boys born with hypospadias. The incidence is somewhat less in the Negro race. About 10 per cent of male siblings will be affected and about the same incidence of offspring of affected males have hypospadias.[5]

This paper discusses hypospadias with a brief review of the embryology, incidence, and classification of the different types. The authors discuss the work-up and latest methods of treatment.

There is some confusion in the literature about classification of the different types of hypospadias. However, it is best to describe the different types dependent on the location of the meatus and presence or absence of chordee. Examples of the different types of hypospadias are shown in Figure 4. A patient can have chordee without hypospadias, but this is less common than pure hypospadias with chordee. About 80 per cent of hypospadias are of the glandular or distal penile type.

When first seen at birth, there are several steps to be taken. The diagnosis is easily made by inspection of the external genitalia. However, it is important to check for other anomalies. Every child with any degree of hypospadias should have a Buccal smear to confirm sex. Careful check should be made for undescended testicles and inguinal hernia since there is an increased incidence of both with hypospadias. If a child is seen with undescended testicles, unilateral or bilateral, and a severe degree of hypospadias, then the possibility of some type of intersex problem should be entertained. More sophisticated work-up will then be needed.[6]

It is important to carefully discuss the problem with the parents during the newborn period. It



Figure 1. Hypospadias—Three-year-old showing hooded prepuce and slight chordee. Pin shows location of meatus.



Figure 2. Hypospadias—Same child as in Figure 1. Hooded foreskin is retracted. Pin shows location of meatus.

should be explained that surgery may be needed at a later date and that if left unrepaired, several problems may develop. First, it will be difficult for the boy to stand to void. Secondly, later in life the ventral curvature will increase with erections and may make intercourse difficult or actually inhibit it completely. Thirdly, there can be severe psychological problems, particularly when the child starts to school.

TREATMENT

It is most important not to circumcise a child with hypospadias since the foreskin is used at the time of surgical repair. Some boys have only a minimal degree of hypospadias with chordee and no repair will be needed. However, in the boy who needs a surgical repair, this should be done between the ages of 2 and 4. The penis is larger at that time, which makes surgery somewhat easier to perform and one would like to have the surgery completed prior to the child starting school.

The objectives of the surgical procedure are two-fold. One is correction of the chordee to straighten the penis and secondly, the construction of a new urethra with the meatus as close to the end of the glans penis as possible. Currently, there are two types of procedures which are popular and give good results. The first type requires two stages done about 6 to 12 months apart. This type is particularly useful for severe degrees of hypospadias, but can be used for all types. The first operation is done to correct the chordee and also places the foreskin on the ventral surface of the penis. The new skin on the ventral surface of the penis is used at the second operation for making a urethra. At the time of the second operation, some type of urinary drainage is used for 10 to 14 days to divert the stream away from the healing urethra.[7]

The results of the procedure are good in experienced hands, but there are complications. The most common complication after the first stage is incomplete correction of the chordee and another pro-

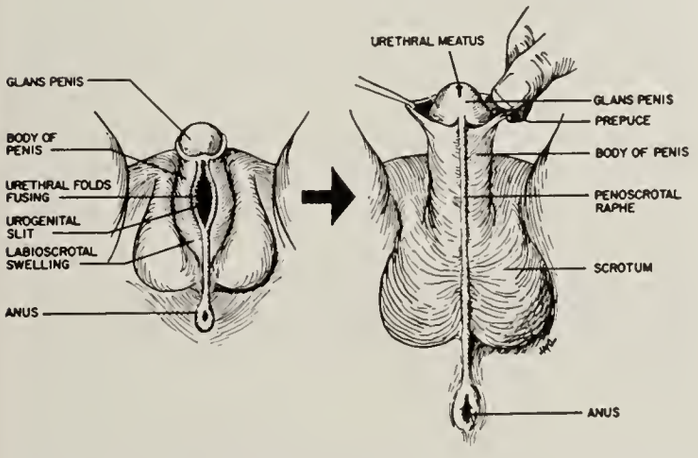


Figure 3. Embryology—Shows the development of normal male external genitalia.

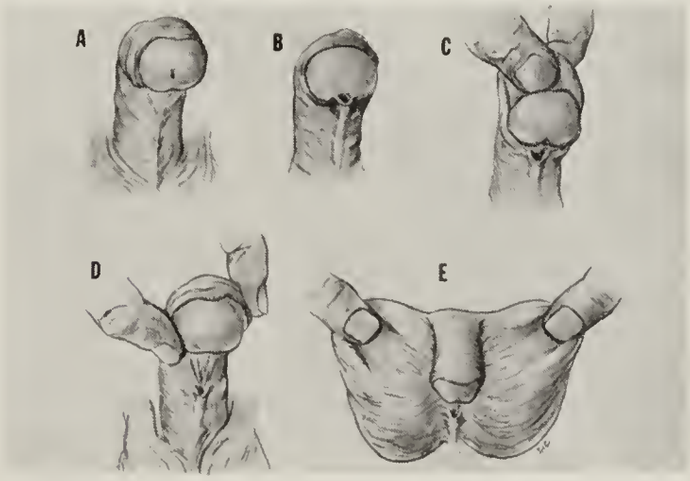


Figure 4. Types of Hypospadias—(A) Chordee without hypospadias; (B) Glandular; (C) Distal penile; (D) Mid penile; (E) Scrotal.



Figure 5. Hypospadias—Three months after one-stage procedure.

eedure will be needed. The most eommon eomplication of the second procedure is urethra-eutaneous fistula which again usually requires another surgical procedure. Fistulae oceur in about 15 to 20 per cent of eases. Other general complications inelude hemorrhage, edema, strieture, and urinary traet infections.

The seeond type of hypospadias repair is the one-stage operation. This is the ideal proeedure sinee both ehordee eorreetion and eonstruetion of a new urethra and meatus are done in one procedure. There are several one-stage proeedures, but the most eommonly used ones are the Horton-Divine[8] and the Hodgson.[9] The Horton-Devine operation is done using a free skin graft from the foreskin for eonstruetion of the new urethra after the chordee is eorreeted. The Hodgson procedure is similar, but uses a pediele graft of the foreskin for eonstruetion of the urethra. The eomplieation rate, partieularly fistulae formation, after the one stage proeedure is about 15 per cent with the Horton-Devine and 3 to 4 per cent with the Hodgson repair. Figure 5 shows the penis 3 months after a one-stage proeedure.

SUMMARY

Hypospadias is not an uneommon entity. If not treated properly, psychologieal and physieal defeets oecur. Recent innovations in surgieal correetion of the entity offer hope for better prognosis. ★★★

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The Criteria Manual of the Mississippi Professional Standards Review Organization

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Jackson, Mississippi

THIS ARTICLE IS the second in a series on the work of the Professional Standards Committee of the Mississippi Foundation for Medical Care. This committee is responsible for directing the development of hospital screening criteria. It is these criteria which support the foundation's concurrent review process being implemented in Mississippi hospitals.

Criteria for medical care are defined as "predetermined elements against which aspects of . . . medical service may be compared." They are developed by members of the profession who rely on professional expertise and on the professional literature. Development and refinement of a uniform set of medical criteria are basic Professional Standards Review Organization activities which should and do provide opportunity for involvement by all member physicians.

The logical application and limitations of screening criteria are generally known. Screening criteria *can* provide an effective review mechanism and *can* reduce physician review time. They provide a guide whereby cases which appear to warrant peer review may be selected. In effect, the screen represents a check point which protects physician review time by directing peer review to those cases where a problem more likely exists. Screening criteria *cannot* and *do not* established rigid standards of quality, define services which will be paid for as part of claims review, eliminate physician innovation, or provide thorough review to evaluate quality of care. Third party reimbursement is based upon overall certification by the PSRO to the third party intermediary that the hospital under binding review is fulfilling its review obligations.

The review process of the MFMC/PSRO covers a large number of patients. All Title V (Maternal and Child Health), XVIII (Medicare), and XIX (Medicaid) patients must be reviewed. These patients account for approximately 40 per cent of all hospital admissions in Mississippi and represent as many as 400,000 admissions annually. Obviously, any review process must be effective and efficient.

Since the screening criteria manual is used by nonphysician review coordinators, it must be explicit enough in the majority of cases not to require the judgment of a physician in determining whether or not a particular criterion has been met. Each item should be based on objective data, easily obtainable from the medical record. Only criteria which measure aspects of practice retrievable from the medical record have been developed. Medical records must therefore be kept current and progress notes written.

MAJOR SECTIONS OF MANUAL

The present screening criteria manual of the Mississippi Professional Standards Review Organization was developed by physicians in the state and is being used in hospitals implementing the review process. The criteria have reached a stage of development that is described as "tentative." While the manual is considered a good basic document, it is to undergo extensive evaluation, refinement and expansion over the next few months. The "tentative" label will be removed only after the document has withstood scrutiny by physicians in actual hospital practice. This phase should be completed early in 1976 when a new edition is scheduled for distribution. The tentative screening criteria manual is divided into three parts: I. "Instructions for Mississippi PSRO Criteria," II. "Listings Applicable to All Criteria Sets and Oncology Specific Materials," and III. "Mississippi PSRO Criteria."

Part I describes the goals of the Standards Committee, the Standards Committee's philosophy of criteria development and clarifications necessary to the understanding of Parts II and III.

Part II is composed of special listings which are:

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- applicable to all of the individual criteria sets, or
- applicable to a large body of the criteria sets, or
- oncology specific, or
- provide a means of addressing diagnoses or problems for which no criteria set has yet been prepared.

Examples of the listings in Part II are:

- admission indicators applicable to any criteria set,
- universal factors for necessity of admission,
- services and management consistent with all diagnoses,
- preoperative services, and
- factors extending length of stay.

Part III contains complete criteria sets for all diagnoses or problems which have been reviewed by the multispecialty physician review panels. These diagnoses total approximately 90. Additionally, there are nearly 20 diagnoses included for which specific admission indicators have been developed. The latter diagnoses will be completed and made a part of the next criteria manual edition. Part III of the tentative screening criteria manual relates to specific diagnostic entities.

The criteria sets are grouped by body system in accord with the body system format of the *Hospital International Classification of Disease Adapted* (H-ICDA) code book. This coding system is widely used in medical record departments throughout Mississippi. This format was selected to assist review coordinators in carrying out the review process, to make *Professional Activity Study* (PAS) length of stay materials more accessible, and to match PSRO computer coding with that already being done in medical record departments.

Each complete criteria set is divided into nine major headings with a basic format as follows:

I. Admission Indicators
II. Essential Services
III. Diagnostic Services Consistent With All Diagnoses
IV. Diagnostic Services Consistent With This Diagnosis
V. Management Consistent With All Diagnoses
VI. Management Consistent With This Diagnosis
VII. Factors Extending Length of Stay
VIII. Indications for Discharge
IX. Validation of Diagnosis

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Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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455

a. *Admission Indicators*

Admission indicators pertain to readily obtainable documentation that hospitalization is necessary in an acute-care inpatient facility. The patient clearly requires more than outpatient or intermediate or long-term nursing home care.

Admission indicators are classified in the criteria sets as emergency or nonemergency. Emergency indicators require that the patient receive inpatient care within 24 hours. Nonemergency indicators are those falling outside the first 24 hours and include both purely elective patients and those requiring more urgent (but not immediate) admission. Emergency indicators may also apply to nonemergency admissions when specified by the admitting physician.

b. *Essential Services*

Here are found those services considered essential for all patients entering the hospital with a particular diagnosis. Essential elements will always be required. These items are: the history and physical examination, complete blood count, and urinalysis.

c. *Diagnostic Services Consistent With all Diagnoses*

d. *Diagnostic Services Consistent With This Diagnosis*

These hospital services are listed in these sections which, although not absolutely essential and required, may be provided for a patient in the course of appropriate medical care. Included in this category are items such as laboratory studies, diagnostic x-ray, scans and angiography, pathology and special studies.

e. *Management Consistent With All Diagnoses*

f. *Management Consistent With This Diagnosis*

Items pertaining to treatment are covered in these sections. Here are itemized all medications, treatments, and surgical procedures which are consistent with a particular diagnosis. This section includes all forms of management and services which might be provided for a patient during the course of his illness. Included are such items as: blood or blood component therapy, drugs, respiratory therapy, surgical procedures, etc.

g. *Factors Extending Length of Stay*

The Professional Standards Committee determined, and this has been affirmed by all multispecialty panels which have met, that nearly all reasons for extending length of stay may be reduced to common major areas. Examples of these major areas are the presence of a concomitant disease or condition, a postoperative complication, and an adverse reaction to therapy. The question this section is concerned with is: *Why* does the patient need continued hospitalization and has this need been documented in the medical record?

h. *Indications for Discharge*

The discharge status of the patient should be the opposite of the reasons for admission. The signs and symptoms present on admission should be absent, controlled, or not likely to improve. Items included in this section therefore identify that the admitting problem has been sufficiently improved so that any further therapy planned may be continued on an outpatient basis, or that the maximum benefits of hospitalization have been obtained.

i. *Validation of Diagnosis*

There should be evidence at the completion of hospitalization to document the diagnosis. The central question is: Did the patient actually have the disease for which he was admitted and treated? A single item such as an EKG report, an x-ray report, or a pathology report will usually be sufficient to provide the necessary documentation. In some cases, validation may only come from the physical examination (i.e., cellulitis from which culture was not obtained).

In next month's article, a specific tentative criteria set will be selected and reviewed in detail. Review and comment from readers regarding the criteria set will be requested. ★★★

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Radiologic Seminar CLVI: Chemodectomas: A Brief Radiological Review

JEFFREY L. SAULS, M.D.
Jackson, Mississippi

THE TERM "CHEMODECTOMA" was originally used by Mulligan in 1950 to describe a tumor arising from the chemoreceptor system of the head and neck.[1] These tumors are named according to their anatomical location, and they include carotid body tumors, glomus jugulare and tympanicum tumors, and vagal tumors. Chemodectomas are uncommon, and they are usually benign and slow growing. Infrequently, they have been known to metastasize.[2]

Carotid body tumors originate in the chemoreceptor located at the bifurcation of the common carotid artery. They usually present as a painless mass in the lateral neck, and they may grow for years before causing significant symptoms. When large they may cause hoarseness or dysphagia, but carotid sinus symptoms are rare.[2]

The "glomus tumors" are highly vascular lesions originating in the mastoid and middle ear regions. Those tumors that involve the middle ear only are usually referred to as "glomus tympanicum tumors," while those that involve the jugular bulb are known as "glomus jugulare tumors."[3] Histologically, these tumors are similar to carotid body tumors. They may produce a variety of symptoms depending on their location. The most common symptoms are progressive hearing loss, tinnitus, and pain. The tympanicum tumors are often detected when the tumor ruptures the tympanic membrane. The jugulare tumors arise from the adventitia of the bulb of the internal jugular vein. They may extend through the roof of the jugular fossa and produce paresis of the ninth through twelfth cranial nerves. The glomus jugulare tumor often invades and extends down the internal jugular vein.

The cervical portion of the vagus nerve is another important site of occurrence for chemodectomas. The term "glomus intravagale" has been used to describe tumors arising in this location. These lesions are extremely rare. They usually present as a painless mass behind the mandibular angle, and they frequently cause a pharyngeal bulge. Chemoreceptor hyperactivity has been demonstrated in some cases, and there may be involvement of cranial nerves IX through XII.[2]

The chemodectomas have a much higher incidence in females than in males. They are usually unifocal in origin, but multifocal tumors occasionally occur. Multifocal presentations include bilateral tumors and simultaneous occurrence of other combinations including glomus jugulare tumors and carotid body tumors and, also, vagal tumors and carotid body tumors.[2, 4, 5]

CASE REPORT

J.P. is a 29-year-old white female who presented with pulsatile tinnitus and a progressive left hearing loss. In addition, she had a non-tender left neck mass which had been present for over a year. A 6 × 8 mm purple tumor mass was seen in the external ear canal and middle ear on otoscopic examination. A 3 × 2.5 cm neck mass was palpated in the region of the carotid bifurcation.

Mastoid x-ray examination revealed sclerotic changes in the left mastoid area suggesting chronic ear disease. Polytomography of the temporal bone showed expansile and erosive changes in the jugular fossa with extension into the middle ear. Retrograde left jugular venography was performed from the right femoral approach, and this revealed an extrinsic pressure effect on the cervical portion of the internal jugular vein (see Figure 1a). In addition, there was intravascular invasion with partial blockage of the jugular bulb (see Figure 1b). These findings are suggestive of carotid body and glomus jugulare tumors, respectively. Arteriography was performed utilizing the right femoral approach. Selective common carotid arteriography revealed a highly vascular tumor at the carotid bifurcation (see Figure 2). The tumor caused a pressure effect with displacement but

Sponsored by Mississippi Radiological Society.
From the Department of Radiology, University Hospital, Jackson, Miss.

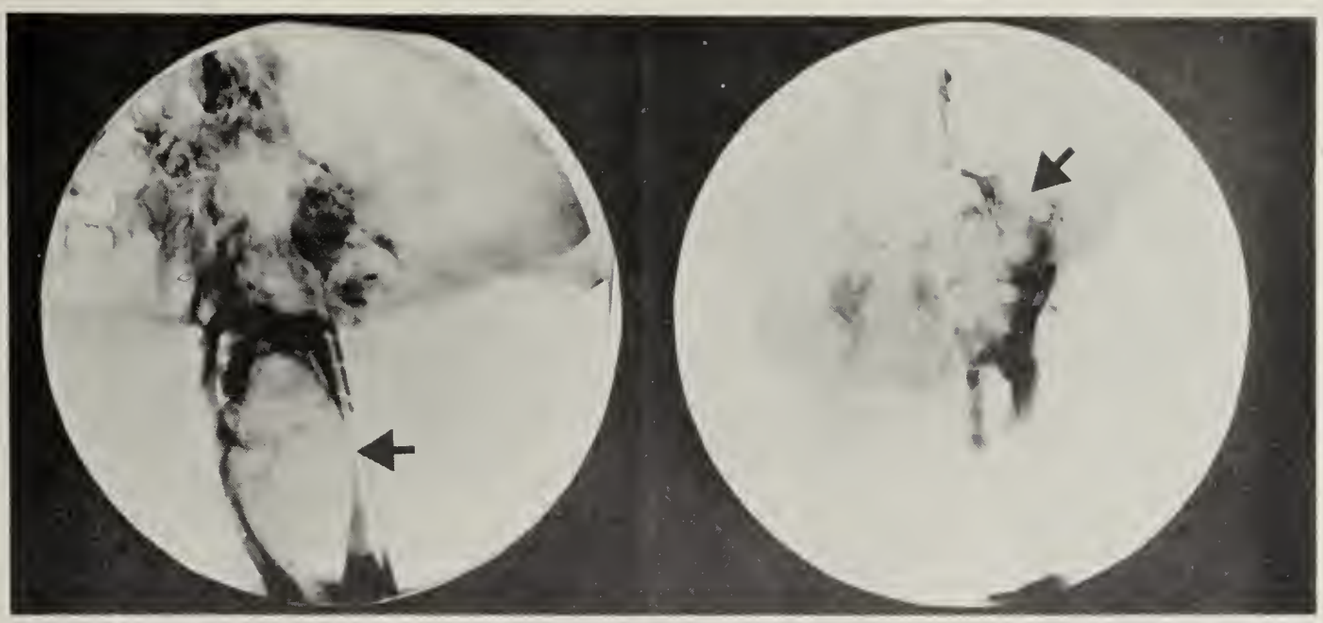


Figure 1. Subtraction films from internal jugular venogram. (a) Compression from the carotid body tumor (arrow) seen in the lateral projection. (b) Compression and partial obstruction at the jugular bulb produced by the glomus jugulare tumor seen in the AP projection (arrow). There is evidence of intravascular extension of tumor which produces a filling defect.

no blockage of the internal and external carotid arteries. Selective left external carotid arteriography demonstrated a vascular tumor in the jugular fossa supplied by branches of the ascending pharyngeal artery (see Figures 3 and 4). Surgical intervention was not undertaken because of the size and location of the glomus tumor. The patient is now being considered for embolization of the glomus tumor followed by surgical resection of the carotid body tumor.

DISCUSSION

Otoscopic evaluation is very important in the evaluation of individuals suspected of having chemodectomas, but even more important is radiologic examination by special x-ray studies. Plain x-ray examination of the skull and temporal bones is often of little value in the diagnosis of glomus tumors because of the dense bone surrounding the site of occurrence. Special views to demonstrate the jugular fossa may be of help, but the definitive diagnosis ultimately requires more specialized studies.

Tomographic evaluation is quite helpful in the diagnosis of glomus tumors. It allows early diagnosis and better delineation of the extent of destruction. Destructive changes may be demonstrated in the floor of the hypotympanum with an associated mass in the middle ear. Erosions of the ossicles and involvement of the external auditory canal may be seen and the petrous pyramids, carotid canals, and hypoglossal canals may also be involved. Asymmetry of the jugular foramina is not significant, for the right foramen is frequently larger.



Figure 2. Subtraction film from common carotid arteriogram in the AP projection. The lower arrow points to the highly vascular carotid body tumor which separates the internal and external carotid arteries. The upper arrow demonstrates an early blush in the glomus jugulare tumor.

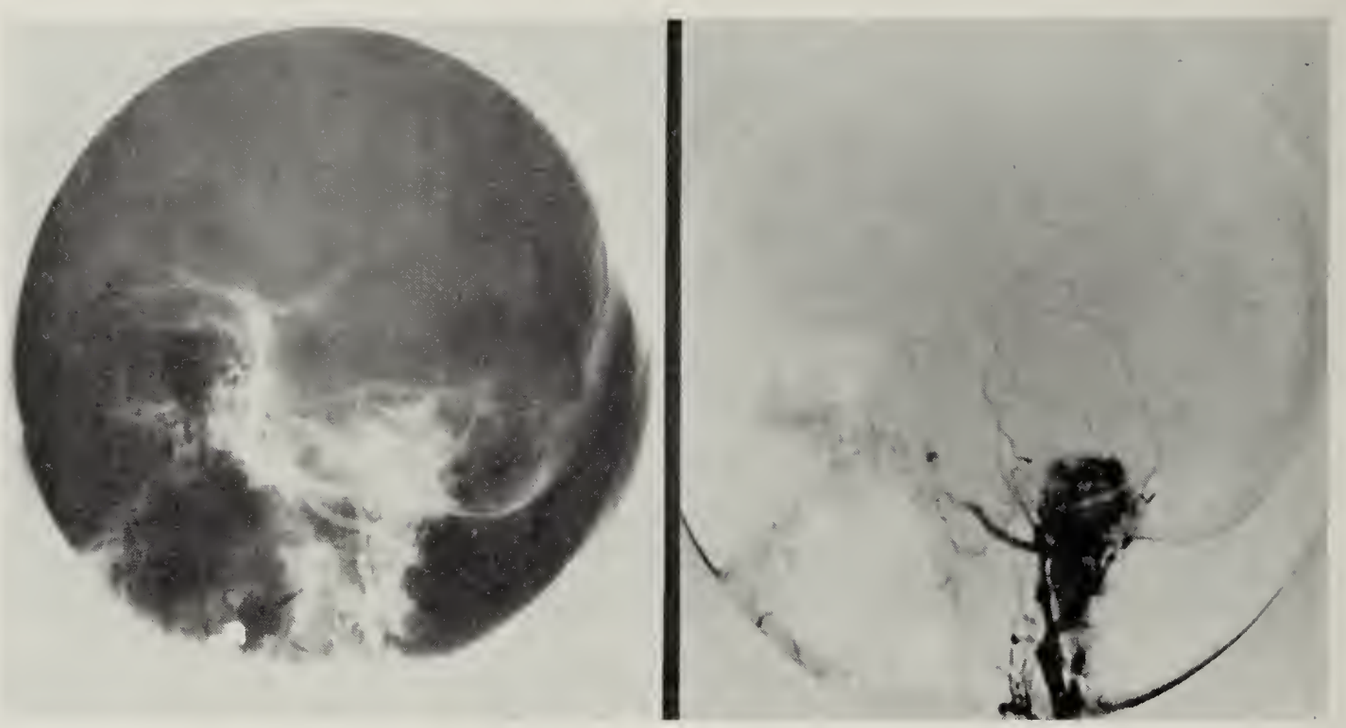


Figure 3. Lateral projections from the external carotid artery injection. (a) A film from the arterial phase of the study illustrates the difficulty in visualization of the highly vascular tumor caused by the overlying dense temporal bone. (b) The same projection has been subtracted, and the highly vascular glomus jugulare tumor is quite obvious.

The retrograde jugular venogram is the most useful study in distinguishing between glomus jugulare and glomus tympanicum tumors. In glomus tympanicum tumors the contrast material should flow freely into the sigmoid sinus, whereas, a jugular tumor usually causes a filling defect or complete blockage of the jugular bulb (see Figure 1b).



Figure 4. AP projection of the external carotid artery injection. The glomus jugulare tumor is well visualized, and it is supplied by branches of the ascending pharyngeal artery.

Carotid arteriography is indicated when the diagnosis of glomus tumor is suggested by other studies. The retrograde femoral approach (Seldinger technique) is recommended, for this allows selection of the external carotid artery and evaluation of the vertebral and contralateral carotid circulations. Glomus tumors are highly vascular and are supplied by tympanic branches of the ascending pharyngeal artery, a branch of the external carotid artery. Selective external carotid injections best demonstrate the tumor vascularity, and the subtraction technique adds much to the examination (see Figure 3). The subtraction technique uses photographic principles to subtract the dense bone overlying the tumor. It may actually be the only method for detecting small glomus tumors.

Carotid body tumors are also highly vascular, and arteriography reveals important information about the size of the tumor and its relationship to adjacent vessels. Common carotid artery injections demonstrate a well circumscribed tumor with collection of contrast material in a small network of vessels (see Figure 2). The carotid vessels are usually separated just distal to the bifurcation, but carotid body tumors rarely cause any significant obstruction. The cerebral blood flow from the opposite side should also be evaluated, for patency of the collateral arteries would

be of extreme importance if surgical ligation of the affected artery became necessary.

SUMMARY

The anatomical, clinical, and radiological aspects of tumors of the chemoreceptor system are briefly reviewed. A case report of simultaneous occurrence of glomus jugular tumor and carotid body tumor is presented. The importance of special radiological procedures in diagnosis of glomus tumors is emphasized. ★★★

2500 North State Street (39216)

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The President Speaking

"The Pressures of Change"

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

IN HIS BOOK *Future Shock* Alvin Toffler describes a kind of stress and psychological disorientation that is induced in people if they are subjected to too much change in too short a time. Discussing the enormous scope and pace of change in our day, Toffler quotes the economist Kenneth Boulding: "The world of today is as different from the world in which I was born as that world was from the day of Julius Caesar, almost as much has happened since I was born as happened before."*

The practice of medicine has not been immune to the enormous pressures of change. The tremendous advances in the science and technology of medicine, the transition from predominately home care to hospital based care, the trend to group practice, and the development of ancillary professions which implement and complement the physician's services are some of the changes to which the profession and the public have had to adjust during the past 25 years. These changes have been scientifically generated and medically motivated and, for the most part, have eventuated in better medical care.

During the past quarter of a century not only has the science of medicine changed but the socioeconomics of medicine have also changed. The advent of the third party as payor has been helpful in defraying the ever increasing cost of medical care but, by the same token the ever important doctor-patient relationship has been altered. National health legislation with its associated bureaucratic rules and regulations has added an additional dimension to the difficulty of adjustment on the part of the physician and the public. No wonder most of us have had an occasional encounter with Toffler's *Future Shock*.

In the midst of so much change what, in our profession, remains constant? I suggest that the work of the physician will always require the union of technical competence and personal integrity in a way that is truly unique among the professions. We will all do well to nurture both areas and to keep our eyes on our primary goal—the delivery of quality health care to our patients. ★★★

* Toffler, Alvin: Future Shock. New York, Random House, 1970, p. 13.

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVI, NUMBER 11
NOVEMBER 1975

EDITORIALS

Hunters' Safety

As the current hunting season opens we are all reminded of the numerous firearm related accidents, resulting in severe injuries and deaths, occurring annually in Mississippi.

To combat this unnecessary loss of life and limb the Mississippi Game and Fish Commission has established a Hunters' Safety Training Program. Available in all 82 counties, this course provides instruction on the proper care and use of firearms and bow and arrow weapons. Sporting ethics, survival techniques, conservation, and game management are also stressed in the course designed to be taught in six hours of classroom lecture and demonstration. Also required is one hour on the firing range. This course, including the firing range portion, is free of charge and on completion of the course all persons over 12 years of age are given a Safe Hunters' Certificate.

To date 37,000 Mississippians have completed this training. Instructors are professional conservation officers and some 600 trained volunteer instructors located throughout the state.

Since the primary aim of the program is to prevent bodily injury to ourselves and others, all physicians interested in hunting should participate in this program and encourage their patients and friends to do the same. By doing this maybe we can reduce significantly the number of hunting related accidents, thereby protecting all of us.

MYRON W. LOCKEY, M.D.
Associate Editor

"People Management" Is Key to Cut Hospital Costs

Better "people management" is one of the major keys to curbing hospital costs, one of the nation's leading hospital management experts said in a recent interview.

Jack B. Anderson, president of Hospital Affiliates International, Inc. (HAI), said that "better scheduling and better training" of hospital employees leads not only to greater cost containment, but also to greater patient satisfaction.

Based in Nashville, Tenn., with several regional offices, HAI manages 35 hospitals and two health maintenance organizations (HMOs), owns 25 hospitals and oversees more than 7,500 beds.

HAI-managed hospitals employ 2.4 employees per patient compared with the 3.6 average of most nonprofit hospitals. The lower figure is attained gradually through attrition, Anderson said.

"In most cases," Anderson said, "HAI has been able to reduce hospital costs by 10 to 20 per cent." Most of the hospitals they manage are nonprofit; some are county hospitals. For many, collection of third party reimbursements contributed substantially to their financial problems.

And contrary to what some physicians and hospital managers believe, Anderson contended that efficiency and good patient care go together. "The more efficiently the hospital is run," he said, "the better it is able to serve its patients."



"Have a nice day!"

Medico-Legal Briefs

NOT EXHAUSTING REMEDIES BARS SUIT AGAINST MEDICARE CARRIER

Where a physician failed to exhaust administrative remedies available to him, a federal trial court in New York ruled that he could not maintain an action against a carrier to recover money withheld for overpayment of Medicare claims.

The physician treated patients enrolled under Part B of the Medicare program. He was paid either by the carrier or directly by his patients, who were reimbursed by the carrier.

When the carrier's Director of Utilization Review became aware of a possible overutilization of Medicare benefits by the physician, he referred a representative sample of the physician's claims to the Peer Review Committee for the Medical Society of the County of New York. The committee confirmed that the physician had been overpaid by $14,457.71.

On Aug. 14, 1974, the physician was formally advised in writing of the determination of overpayment. He was told that he had the option of either refunding the amount to the carrier or having amounts due him from unpaid claims used to offset overpayment until the whole amount had been recovered. He was given two weeks to reply and seek a hearing for review of the determination of overutilization.

The physician failed to reply to the letter and was informed by another letter, on Sept. 24, that in view of his silence, payments on future claims were being suspended to offset the overpayment. Instead of requesting administrative review, the physician instituted an action in court to recover a portion of the money withheld by the carrier. The carrier moved to dismiss the suit for failure to exhaust administrative remedies.

The court said that the carrier had established a review procedure according to law. Because the physician had failed to pursue the administrative remedies of which he had been informed, the court could not review the determination of overutilization.

If the physician had exercised his right to a hearing, the court said, he could have challenged the manner in which the carrier determined utilization and the amount thereof. By his failure to do so, the physician deprived the carrier of a chance to correct any errors.

The carrier informed the court that if requested it would reopen its proceedings and extend the time within which the physician could pursue his administrative remedies. Granting the carrier's motion on the condition that the physician be permitted two weeks in which to avail himself of such remedies, the court found that if the physician failed to act within the allotted time the carrier could submit an unconditional order of dismissal.—*Weinreb v. United Medical Service, Inc.,* 392 F.Supp. 45 (D.C., N.Y., April 1, 1975)



O. J. ANDY of Jackson and UMC presented two papers before the International Society of Psychiatric Surgery Congress in Madrid, Spain.

ERNEST F. APPLE and ROBERT C. BALLARD are now located in the doctors' clinic adjacent to Marshall County Hospital in Holly Springs.

ED DALTON BARHAM has associated with JAMES B. BARLOW and Associates, P.A., for the practice of radiology at 514-B East Woodrow Wilson in Jackson.

RICHARD C. BORONOW of Jackson and UMC served as co-chairman of the Quality Control Committee, Gynecology Oncology Group, meeting in Rochester, N. Y.

WALTER BOURLAND of Tupelo has been named to a recently formed Perinatal Advisory Council aimed at improving perinatal care for health department patients throughout Mississippi.

DAN L. BRASFIELD has associated with Drs. Stacy, Blakey and Trapp, P.A., for the practice of diagnostic radiology and nuclear medicine at 835 South Gloster in Tupelo.

ROBERT L. BUCKLEY, JR., announces the opening of his office for the practice of pediatrics and adolescent medicine at the Family Medical Building, 321 Hospital Drive, in Columbus.

CARLOS M. CHAVEZ of Jackson was in Milwaukee Sept. 16-19 for a Wisconsin Heart Association symposium on coronary bypass surgery.

LARRY DAY of Hattiesburg and J. GEORGE SMITH of Jackson attended the Second Annual Symposium on Plastic and Reconstructive Surgery of the Head and Neck in Chicago.

ALBERT L. M. DIAZ has opened his practice in obstetrics and gynecology in association with ROBERT J. SCHMIDT and M. E. COCKRELL, JR., at the Medical Plaza offices on Vancleave Road in Pascagoula and at 137 Lameuse Street in Biloxi.

C. MIMS EDWARDS of Brandon announces the opening of offices at Suite IV, Crossgates Plaza, for the practice of psychiatry in adolescents and adults.

JOHN EVANS of Vicksburg was elected president of the Mississippi Division of the American Cancer Society at the annual meeting in Jackson. Named as president-elect was DAVID OWEN of Hattiesburg. Other officers are: FRANCIS MORRISON of Jackson, first vice president; WALTER BOURLAND of Tupelo and WALTER ROSE of Indianola, area vice presidents; and JAMES P. SPELL of Jackson, executive committee.

JAMES D. HARDY of Jackson and UMC spoke on the heart in shock and on hormonal factors in cancer growth and treatment and presided at the session on shock at the International Society of Surgery meeting in Edinburgh, Scotland. GEORGE V. SMITH of Jackson and UMC presented a paper at the same meeting.

MICHAEL E. JABALEY of Jackson and UMC went to Paris, France, for the Sixth International Congress of the International Confederation for Plastic and Reconstructive Surgery. He presented a paper and participated in a round table discussion on tactile sensitivity.

DWIGHT S. KEADY has associated with WILLARD H. BOGGAN and JAMES P. HOLLOWAY for the practice of internal medicine at 500-M East Woodrow Wilson in Jackson.

JAMES KEETON of Jackson announces the relocation of his offices to 971 Lakeland Drive, Suite 201, for the practice of urology and pediatric urology.

HERBERT LANGFORD of Jackson and UMC addressed the National High Blood Pressure Education Program Task Force on Pediatric Hypertension meeting in Chicago. He spoke on "sodium, diet and adolescent hypertension."

LARRY LIPSCOMB of Jackson announces his association with PAT BOND and the relocation of offices to 5451 Robinson Road Extension, Jackson 39204.

GLENN F. MORRIS announces the opening of his office for the practice of family medicine at Doctors Hospital Professional Building, 385 Medical Drive, Jackson.

FRANCIS S. MORRISON of Jackson and UMC attended the Southeastern Regional Meeting of the American College of Physicians at Point Clear, Ala. He also presented a paper on regionalization to the National Association of Regional Medical Programs in San Diego in a program entitled "development of a health system for the community."

ORLANDO A. PATINO-GAMBOA has associated with Laird Hospital in Union for the practice of family medicine.

GLENN B. RICHARDSON announces the opening of his office for the practice of general medicine at the Columbus Hospital, 1001 Main Street in Columbus.

JAMES H. SAMS announces the opening of his office for the practice of family medicine in the Family Medical Building at 321 Hospital Drive in Columbus.

G. BOYD SHAW and B. T. HICKMAN of Jackson are new members of the board of directors of the Hinds County Unit, American Cancer Society.

DONALD M. SHERLINE of Jackson and UMC participated in the Baylor College of Medicine Department of Ob-Gyn "great debates in ob-gyn" program in Houston.

BENNETT E. SMITH, JR., announces the opening of The Hattiesburg Adolescent Clinic at 212 S. 27th Avenue in Hattiesburg. Dr. Smith will limit his practice to patients from 12 years old through college age.

W. LAMAR WEEMS of Jackson and UMC participated in the American Urological Association Council on Education meeting in Chicago.

CARL WELCH of Corinth spoke to biology students at Corinth High School on the outbreak of encephalitis.

POSTGRADUATE CALENDAR

Nov. 3-5, 1975

Urology Intensive Course
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinator:
James E. Keeton, M.D., assistant professor of surgery (urology) (part-time), the University of Mississippi School of Medicine

This course is structured to give the primary physician an overview of the current methods of diagnosing and treating common urological diseases. Topics to be covered include urinary tract infections; benign prostatic hyperplasia; cancer of the prostate, kidney, and testicles; stones; septicemia; urethral strictures; trauma; infertility and impotence; catheter care; and the neurogenic bladder. Fee for the course is $75.00.

Nov. 10-14, 1975

Pediatrics Intensive Course
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinator:
J. M. Montalvo, M.D., professor of pediatrics, the University of Mississippi School of Medicine

Participants will cover special problems in newborn care and neurology, with a special emphasis on convulsive seizures, meningitis and head trauma. Other topics include care and problems of the adolescent, allergy, hematology, oncology, pediatric emergencies, cardiology, radiology, fluid and electrolytes. Discussions of nephrology, endocrinology, inhalation therapy, pediatric surgery, and orthopedic problems in children are also planned. Each registrant will participate in specialized pediatric techniques and will make daily intake and ward rounds. Course fee is $125.00.

FUTURE CALENDAR

Jan. 12-16, 1976
EKG Intensive Course

Jan. 26-30
Nephrology Intensive Course

Jan. 30-31
American College of Physicians Regional Meeting

Feb. 23-25
Urology Intensive Course

Mar. 3-5
ENT Intensive Course

Mar. 11-13
Surgical Forum III

Mar. 18-20
Neurology/Neurosurgery Intensive Course

Mar. 22-26
Pediatrics Intensive Course

Mar. 24-27
American College of Physicians Hematology/Oncology Conference

April 5-9
Pulmonary Intensive Course

April 19-23
Nephrology Intensive Course

May 3-6
Mississippi State Medical Association

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers intensive refresher courses to meet physicians' clinical practice needs in the specialties most requested. Mississippi Regional Medical Program partially supports the series open to all physicians. Intensive courses are eligible for AMA Physician Recognition Award Category I credit. Enrollment is limited, and applications are accepted in the order received. All correspondence about intensive and other courses should be addressed to Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

Book Reviews

Respiratory Research in the People's Republic of China. By Frederick F. Kao, M.D., Ph.D. 141 pages with illustrations. Washington, D. C.: DHEW Publication No. (NIH) 75-770, 1975. $1.75.

Dr. Frederick Kao graduated from medical school in China but for the past 25 years has lived mostly in the United States. He is a noted respiratory physiologist and has written knowledgeably concerning the regulation of ventilation.

The monograph, *Respiratory Research in the People's Republic of China,* which was written by Dr. Kao for the Geographic Health Studies, John E. Fogarty International Center, is an attempt to explain to the occidental scientist what's been going on recently in China in the field of respiration. Pages 117-120 "Conclusion and Future Prospects" would have been quite enough, but alas, the pages go to 140 and we are treated to such titillating bits of nonsense as rhododendron "can arrest cough, loosen sputum, and treat chronic bronchitis and chronic cough." This volume, unfortunately, will do little to further the foundation's raison d'etre which is to disseminate comparative knowledge of the health care systems of other countries. The numerous photographs are more anecdotal than informative and might well have been taken by my great-aunt Bernice who was a magnificent herbal gardener.

The extraordinarily complex Oriental physiologic concepts culminate in the Yin-Yang and Five-Elements Doctrine where the lung (a Yin organ) is pictured coupled to the large intestine (a Yang organ). As a western pulmonary physiologist, I can see only one byproduct of having the lung connected to the large intestine, and that isn't gas exchange—if you will pardon the pun. How these and other sources of Chinese medicine could be fused in the 1966 establishment of the new Chinese medical system is not made clear by even such an eminent physiologist as Dr. Kao.

Joe R. Norman, M.D.
Jackson, Miss.

Legal Aspects of Drug Dependence. Edited by R. J. Bonnie, and M. R. Sonnenreich. 367 pages. Cleveland, Ohio: The CRC Press, 1975. $65.00.

This book is one of a series on drug dependence, the others dealing with chemical and biological aspects, sociological aspects, and psychiatric aspects of drug dependence. The series, according to S. J. Mule, Ph.D., editor-in-chief, is intended as "an authentic primary reference source of data and information for anyone with an intense interest in this drug problem."

The editors of this particular book in the series were Executive and Associate Directors of the National Commission on Marihuana and Drug Abuse and were reporters for the Uniform Drug Dependence Treatment and Rehabilitation Act. It is not surprising, therefore, to find that the six papers presented by outside contributors all appeared in Volume IV of the Appendix to Drug Use in America: Problem in Perspective, the Second Report of the National Commission on Marihuana and Drug Abuse (1973). Two of the monographs, "Legal Intervention and the Drug User," and "The Role of the Law in Treatment," were exerpted from the final report of the National Commission on Marihuana and Drug Abuse and one was based on the National Conference of Commissioners on Uniform State Laws.

Perhaps a better title for this volume might be Legal Aspects of Drug Dependence Treatment. Consideration of the laws regarding restriction or prohibition of dependence-producing drugs are not covered, nor private legal relationships of dependent persons, nor implications of public law. Rather, it concentrates only on the coercive aspects of the law and the intersections of law and therapy.

The book is divided into three parts. Part one is concerned primarily with the grounds that society is justified in asserting control over drug dependent persons. The first paper, "Legal Intervention and the Drug User," questions the right of the state to place restraint on individual liberty, including the consumption of psychoactive substances. An overview of historical possession offenses is presented, and the constitutionality of the restriction of the right of

privacy is considered. They conclude that, "At best it is possible to construct only a contingent emergency rationale for limited prevention intervention," and "only short term emergency control over persons who are incapacitated by psychoactive substances or who require medical attention for acute adverse effects of such substances."

The second paper is a set of historical materials compiled by one of the editors (Bonnie) to illustrate the initial legislative implementations of an intervention approach to drug use and drug dependence. A multitude of tables list various statutory prohibitions regarding drug use and possession from 1885 to 1930. Once again the conclusion is, "Intervention is undoubtedly required in some cases. But the reach of the law clearly exceeds the class of individuals who require leverage or control."

"Therapeutic Justice" discusses the broad philosophical questions which are raised when the justification for legal control changes from punishment to therapy. It first discusses the problems with the therapeutic model and then suggests ways to avert these problems with procedural safeguards and substantive standards for the exercise of the state's police power and parens patriae jurisdiction.

The final paper in part one, "Constitutional Dimensions of Civil Commitment," analyzes the issues raised by the commitment of drug dependent persons. The recent United States Supreme Court ruling and the changes in state laws regarding commitment, however, have already, to a large extent, rendered these issues obsolete.

Part II deals with "Legal Dimensions of Drug Dependence Treatment." In every case, these monographs must be read as historically oriented material. Much of what is written and charted here is no longer applicable as drug laws have undergone dramatic changes since early 1973 when these papers were presented to the National Commission of Marihuana and Drug Abuse. This is especially true of "Analysis of Drug Treatment Laws in the 50 States and 5 Territories," which is correct only to March 1973, and should be kept in mind with the article on confidentiality. Each of these papers includes numerous charts of federal and state laws which may or may not be accurate at this time. The articles on NARA and maintenance of opiate-dependent persons are also interesting from an historical standpoint of federal involvement with treatment which has run the gamut from prohibition to promotion. With the creation of new federal programs, cut-back in funding, and dissolution of others such as BNDD and SAODAP, the legal aspects of treatment programs are constantly undergoing change.

Part III, "New Departures in Law and Therapy," includes the Uniform Drug Dependence Treatment and Rehabilitation Act which was designed to rationalize the operation of the state legal systems in the treatment of drug dependent persons, and to promote uniformity among existing state laws. It was completed in March 1973, approved in August 1973 by the National Conference of Commissioners on Uniform State Laws (also responsible for the Uniform Controlled Substances Act of 1970) and endorsed by the American Bar Association in February 1974. The act is spelled out in full here with interesting comments throughout to make it easily understandable. It is followed by "A Proposed Federal Drug Dependence Treatment and Rehabilitation Act" written by the editors, Bonnie and Sonnenreich. This act was written to replace NARA (the Narcotic Addict Rehabilitation Act of 1966) and the Drug Abuse Office and Treatment Act of 1972.

Any book considering legal aspects of drug dependence would be difficult at best because of the scope of the subject as well as the problem of instant obsolescence in the field of drugs. This book, too, suffers from dating in spite of the fact that it was just published because of the rapidly changing laws, both on a state level and federally. As a result of this, the use for which it is intended, as well as the cost, must be given much consideration. The other volumes in this "Uniscience" series of drug dependence will be far more helpful as reference texts.

JOHN F. RUSSELL, M.D.
Gulfport, Miss.

LETTERS

SIRS: Recently I have been concerned about the inadequate knowledge of the use of the insect sting emergency first-aid kit, and also its being unavailable to those who should have it on hand in case of a severe insect sting reaction. For example, the following groups of people usually do not have the kit nor the knowledge of its use and yet they are most likely to be faced with this situation: school nurses or principals, forest rangers, scout masters, golf pros, swimming instructors, and tennis pros. I feel that

some deaths could have been prevented by making this kit available to these people, with instructions for its use.

I have been given to understand that it is against the law for these people to give injections and yet we physicians give insect sting kits to our insect allergy patients and train them in their use. I think that the law should be changed. These people should be trained in the use of the emergency insect sting kit and allowed to give the medication in cases of a life or death situation. I hope others feel the same as I and will help to get the laws changed so that this can be done.

I know of two instances where the use of this kit could have prevented death in the individual who suffered the severe reaction. I would appreciate hearing from others who know of similar cases in which the use of an insect sting kit would have prevented the death of a person.

CLAUDE A. FRAZIER, M.D.
Doctors Park, Bldg. 4
Asheville, N. C. 28801

EDITOR'S NOTE:

MSMA member Dr. J. George Smith of Jackson requested that the JOURNAL reprint this letter from *Postgraduate Medicine*, Vol. 57, No. 3, March 1975, copyrighted by McGraw-Hill, Inc. Dr. Smith feels the letter is very informative regarding the status of the practitioners of plastic surgery. Dr. Trent Smith is president of the American Academy of Facial Plastic and Reconstructive Surgery.

SIRS: At a time when federal agencies and hospitals are especially concerned with definitions, privileges, and capabilities, it behooves an enlightened medical profession to reflect on who's who in the growing field of plastic surgery. We tend to rely on semantics and impressions. If plastic surgery is needed, we may turn to a plastic surgeon because he is a specialist. That tendency is fine, but in following it, we fail to recognize the many practitioners of plastic surgery who do not use the title "plastic surgeon."

Basically, plastic surgery is both a method and a medical specialty. In effect, the plastic surgeon is a specialist in the method. He is obviously a practitioner of plastic surgery, is certified by the American Board of Plastic Surgery, and is officially designated a plastic surgeon. There is virtually no chance of anyone misunderstanding his scope of medical practice.

Who, then, are the other practitioners of plastic surgery? They are specialists in a particular region or organ of the body, for example, ophthalmologists, who after certification by the medical board in their specialty, subspecialize in plastic and reconstructive surgery. Thus, during their specialty training, they master both the specialty region and the method of ophthalmic plastic surgery. Some of these specialists have become known as regional plastic surgeons.

Unlike general plastic surgeons, regional plastic surgeons do not present a consistent identity pattern. Some otolaryngologists may practice under the title "head and neck plastic surgeon" or "cosmetic facial surgeon." Other regional specialists may add the term "plastic surgeon" to their specialty title, for example, the ophthalmic plastic surgeon and the dermatologic plastic surgeon. Still others, such as orthopedists, obstetrician-gynecologists, urologists, neurosurgeons, colon and rectal surgeons, and general surgeons, do not usually add the term "plastic" to their specialty title, although they may use plastic and reconstructive surgical techniques.

A leading ophthalmic plastic surgeon estimates that 1,000 ophthalmologists do a significant amount of plastic and reconstructive surgery. The chief of one otolaryngology residency training program estimates that 4,000 otolaryngologists perform regional plastic and reconstructive surgery. A prominent dermatologist estimates that 300 members of his specialty practice plastic surgery.

About 180 maxillofacial surgeons spend all their time doing plastic and reconstructive surgery. Virtually all of the neurosurgeons, estimated at 2,000, perform cranioplasties for skull defects. Most of the 9,200 orthopedists practice plastic and reconstructive surgery, because that in the broadest sense is the nature of their work. Many of the 6,000 urologists do some plastic reconstructive surgery in their specialty area, as do many of the 30,000 general surgeons who apply plastic techniques in repairing hernias, strengthening the abdominal wall, removing tumors and ulcers, working with or operating burn units, and repairing defects with skin grafts.

Conservative estimates from the most pertinent medical specialties suggest that about 22,000 American physicians practice regional plastic surgery. Of that total, more than 7,000 perform plastic and reconstructive surgery in the head and neck area alone. The significance of these numbers is seen when they are compared with the number of specialists, an estimated 1,500, who are designated plastic surgeons.

Obviously, no medical specialty has the exclusive capability to perform plastic and reconstructive sur-

gery. No board certification by any specialty and no medical title can guarantee a fine surgical result. In discussing plastic surgery with our patients, we might well remember that there are good, fair, and poor surgeons in all specialties. The most important consideration, therefore, is not the surgeon's title but his ability as manifested by his results.

TRENT W. SMITH, M.D.
Columbus, Ohio

Dr. Paul Derian Is Tapped by SICOT

Dr. Paul S. Derian, professor of surgery and chief of the division of orthopedics at the University of Mississippi School of Medicine, has been elected to active membership in the United States Section of SICOT.

The International Society of Orthopedic Surgery and Traumatology (SICOT) is the only international organization which taps members from the American Academy of Orthopedic Surgery. In 1973 and 1974, only 19 Americans were selected.

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Dr. Derian is the first known Mississippian included in the 400-member group. He has been on the UMC faculty since 1960.

1976 Arts Festival Announces Plans

The 1976 Mississippi Arts Festival is scheduled for April 23-May 1 in Jackson.

The weeklong event will move from its traditional state fairgrounds home this year for a special festival salute to Mississippi's heritage and the nation's 200th birthday.

"Most events will take place along Jackson's historic Capitol Street," said '76 chairman Mrs. C. Chandler Clover. "We're calling this portion of the weeklong event 'street scene,' and its opening at 6 p.m. on Friday, April 23, from the steps of the Old Capitol will kick off festival activities."

The street will be blocked to traffic through Sunday, she added, to make way for special shows, sidewalk cafes featuring ethnic foods—and exhibits from the best of the state's and the south's artists.

Performing arts attractions are planned for nearby historic Smith Park, in the "vacant spaces and places" along Capitol Street and its connecting north-south arteries, in the churches in the center city, and on the Capitol Green. And, as always, festival planners say there'll be "best of nation's artistic talent" on hand to headline evening events at city auditorium, or the state coliseum.

Other special programs during festival week will include a Black culture seminar, to be coordinated by one of the nation's most prominent Black writers; a children's division, offering historical displays of toys and trains—plays and Jackson Symphony Orchestra youth concerts; the bicentennial Freedom Train which will be in Jackson for festival week; walking tours of historic locales in the center city; and other seminars and performing programs emphasizing city, state and national heritage.

Tickets will be available in varying price ranges for the headline attractions, and there will be a nominal fee charged for certain special seminars, plays and other shows. But many events, as always, will be free, Mrs. Clover pointed out.

"The festival is a statewide event," she added, "so we hope all Mississippians, and many from our sister states, will join us in April for this special salute to our cultural heritage."

Mississippi Public Health Association Holds Annual Meeting in Jackson

The Mississippi Public Health Association held its 38th annual meeting in Jackson Oct. 8-10 at the Holiday Inn-Downtown. The theme of the meeting was "The Task of Public Health."

The meeting included addresses by leading public health physicians and administrators from across the United States. Six section meetings were held in different areas related to public health.

Dr. Milton Terris, professor and chairman, Department of Community and Preventive Medicine, New York Medical College, addressed the Wednesday afternoon session of the meeting on "Health Departments and the Second Epidemiologic Revolution."

Fred Hering, Ed.D., director of professional education of the American Public Health Association, also addressed the Wednesday afternoon session on "Your Image Is Showing."

Dr. Alton B. Cobb, Mississippi State Health Officer, and Dr. Roy E. Albert, deputy assistant administrator for health and ecological effects for the U. S. Environmental Protection Agency, spoke at the Thursday morning session.

Dr. Cobb's topic was "Public Health Now and in the Future." He predicted a bright future and continued growth for public health in the state. He also reiterated progress in major program areas of the State Board of Health such as Maternal and Child Health, Environmental Health and Disease Control.

James E. Word, deputy commissioner of the Tennessee Department of Public Health, presented the keynote address of the final session on Friday morning. His talk was on "Major Trends in Public Health 1976."

Mrs. Mary Elizabeth Harwell, a public health nurse in Clarke County for 28 years, was presented the first annual Felix J. Underwood Award. The award is given for outstanding service and achievements in public health. Dr. Underwood was the first state health officer from 1918 to 1946.

T. W. Williamson, chief of the bureau of administrative services, State Board of Health, served as president of the association during the meeting. Joe Cone, director of chronic disease control, is the new president of the association while Dr. Frank M. Wiygul, Jr., chief of the bureau of family health services, is the president-elect.

Addressing section meetings were Monroe Lerner, Ph.D., School of Hygiene and Public Health, Johns Hopkins University; Dr. Nancy Milio, associate in nursing, department of nursing, Simmons College, Boston; Pat T. Nunnelee, district sales manager, Life and Casualty Insurance Company of Tennessee; Dr. Jacob Koomen, secretary and state health director, North Carolina State Board of Health; Ms. Eleana Turner, editorial assistant, State Department of Archives and History; and Wallace Vernon Mann, Jr., D.M.D., dean of the University of Mississippi School of Dentistry.



Dr. Alton B. Cobb, State Health Officer, addresses the 38th annual meeting of the Mississippi Public Health Association in Jackson.

University Medical Center Marks 20th Anniversary

The University of Mississippi Medical Center marked the 20th anniversary of its opening this fall, with 12 physicians and five other faculty who had helped get the center started in 1955 still on hand.

Of the 450 original employees, a total of 64 faculty members, officers of the administration, non-academic department heads, and employees in such support areas as nursing service, housekeeping, physical plant, and a variety of offices were honored with a one-time 1955 award at a special recognition ceremony. Faculty and officers of the administration who had served the School of Medicine for 20 years also received chairs at a separate ceremony.

Since the Medical Center opened two decades ago, 2,594 health care professionals have been graduated, including 1,296 who got M.D. degrees, 462 baccalaureate nurses, graduate degree recipients, and those who earned certificates and degrees in a dozen other health care fields.



University of Mississippi Medical Center faculty and officers of the administration with 20 years service got captain's chairs bearing the University crest and engraved nameplates at special recognition ceremonies in September. Recipients included, front, from left, Mrs. Maurine C. Twiss, Miss Irene Graham, Dr. Margaret Batson; standing, Frank C. Zimmerman, Dr. W. Forrest Hutchison, Dr. David Wilson, Dr. Robert D. Sloan; and, not present, Dr. Orlando J. Andy, Dr. Blair Batson, Dr. Warren N. Bell, Dr. Thomas M. Blake, Dr. James D. Hardy, Dr. Herbert G. Langford, and Dr. M. Don Turner. Vice Chancellor Dr. Norman C. Nelson, second right, and Chancellor Porter L. Fortune, Jr., right, congratulate the awardees.

Student enrollment has grown from 165 that first year to nearly 1,400 this academic session. The faculty has increased from 33 to 307, and the number of education programs from three to 16 to meet Mississippi's need for health professionals.

Physicians who got the 1955 award were Dr. Orlando J. Andy, professor of neurosurgery and chairman of the department; Dr. Blair E. Batson, professor of pediatrics and chairman of the department; Dr. Margaret Batson, associate professor of pediatrics; Dr. Warren N. Bell, professor of clinical laboratory sciences and chairman of the department; Dr. Thomas M. Blake, professor of medicine; Dr. Thomas J. Brooks, professor of preventive medicine and chairman of the department; Dr. Arthur Guyton, professor of physiology-biophysics and chairman of the department; Dr. James D. Hardy, professor of surgery and chairman of the department; Dr. Herbert G. Langford, professor of medicine; Dr. William A. Neely, professor of surgery; Dr. Robert D. Sloan, professor of radiology and chairman of the department; and Dr. David B. Wilson, assistant vice chancellor for special projects and health planning.

Among other 20-year award recipients were Dr. Jack W. Crowell, professor of physiology-biophysics; Dr. Lanelle G. Gafford, associate professor of microbiology; Miss Irene Graham, director of Rowland Medical Library; Dr. W. Forrest Hutchison, professor of preventive medicine; Dr. Louis L. Sulya, professor of biochemistry and chairman of the department; Mrs. Maurine C. Twiss, director of the Department of Special Services and Campus Relations; and Frank C. Zimmerman, comptroller.

Texas Internists Meet Dec. 4-6

Specialists in internal medicine and related medical fields will hold a three-day scientific meeting on Dec. 4-6, 1975, in San Antonio.

Physicians who attend the regional meeting are eligible for credit toward the American Medical Association Physician's Recognition Award in Category #1.

In charge of arrangements for the Texas Regional Meeting is Dr. Don W. Chapman, Houston, who serves as the ACP's representative in the state of Texas.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



Woman's Auxiliary to the Mississippi State Medical Association

Those who view the Woman's Auxiliary to the American Medical Association as a conservative organization would have had to rethink their views had they attended the 1975 convention. Important changes were made, including a change of name to American Medical Association Auxiliary, in keeping with the policy of accepting both husbands and wives of physicians as members. In addition, the house of delegates voted a $3 increase in dues, bringing national dues from $4 to $7, and changed the bylaws to meet current demands of economy and programming. With these national changes will come many changes in our own state bylaws.

We're moving in new directions, as rightly we should, because as each year passes we're faced with new challenges. As auxiliary members and physicians' wives, we must be prepared to face these challenges side by side with our husbands. This means that we must be knowledgeable about National Health Insurance, Malpractice Insurance, and countless other legislative issues—and must work to help solve them to the patients' best interest.

The American Medical Association Auxiliary has only one fund raising project, and that is the American Medical Association Education and Research Foundation. The purpose is two-fold: (1) to provide unrestricted grants to medical schools and (2) to enable medical students, interns, and residents to obtain low-interest loans not otherwise available. Unrestricted grants are important because deans of medical schools are always in need of flexible financial aid.

We all should be vitally interested in the future of medicine in this country and the betterment of medical education. We want this to be a banner year for our Bicentennial, so an even bigger goal is set for AMA-ERF. We urge each auxiliary member and physician in our state to contribute a minimum of $10.00 to AMA-ERF. Contributions can be mailed to State Auxiliary Chairman: Mrs. W. P. Warfield, 2117 Briarwood Drive, Moss Point, Miss. 39563, or to: Mr. Bill Price, Alumni House, 2500 North State Street, Jackson, Miss. 39216. Please let us know if your contribution is a memorial or "In honor" of someone. All contributions are *tax deductible!* Every dollar goes to the program and medical school of your choice.

In March of 1975, the University of Mississippi School of Medicine received a check totaling $12,211.35, from *your* contributions to AMA-ERF. They need our support now more than ever. Let's make this a record-breaking year.

TAKE TIME for Medical Education!

Mrs. J. Edward Hill
President, WA/MSMA

Miss. Medical, Dental Workshop Held



Dr. Earnest Rankin, left, and Dr. Willye Powell, right, were among minority health professionals who attended the Mississippi Medical and Dental Workshop the University of Mississippi Medical Center hosted. Dr. T. D. Lampton, center left, Mississippi Regional Medical Program coordinator, and Dr. Joel Tate, Gulfport dentist, talked with them about the need for more minority health professionals in Mississippi and the opportunities for practice. Dr. Rankin, a Mendenhall native, is a UMC graduate now in residency training at the Academic Health Center in Amarillo, Tex. Dr. Powell, from McComb, is a pediatric resident at the Martin Luther King Hospital in Los Angeles, Calif. She's a graduate of Meharry Medical College.

MHIC Seeks HSA Approval

The Mississippi Health Improvement Corporation, a nonprofit corporation chartered by the state of Mississippi, has officially notified the Department of HEW of its intent to seek designation as the Health Systems Agency for Mississippi under requirements of Public Law 93-641, the National Health Planning and Resources Development Act of 1974.

Public Law 93-641 provides for consolidation of the present Regional Medical, Comprehensive Health Planning and Hill-Burton programs under a system of local and state planning and development agencies operating within guidelines to be established by the Secretary of HEW.

The law has been highly criticized by the American Medical Association because of its potential for HEW control of present local and state health planning and funding prerogatives. Opponents of the law cited it as a mechanism to make health care a public utility by regulating health facilities construction and rates.

Members of the Board of the Mississippi Health Improvement Corporation are: William K. Ray, chairman; T. D. Lampton, M.D., president; Lewis Nobles, Ph.D., vice-chairman; R. W. Harrison, Jr., D.D.S., secretary-treasurer; John C. Bonner; Guy D. Campbell, M.D.; S. D. Craig; A. A. Derrick, Jr., M.D.; Levin Farmer; Charles W. Flynn; Foster Lowe, M.D.; Norman C. Nelson, M.D.; Alfio Rausa, M.D.; and Paul K. Shannon, O.D.

UMC Now Has An EMI Scanner

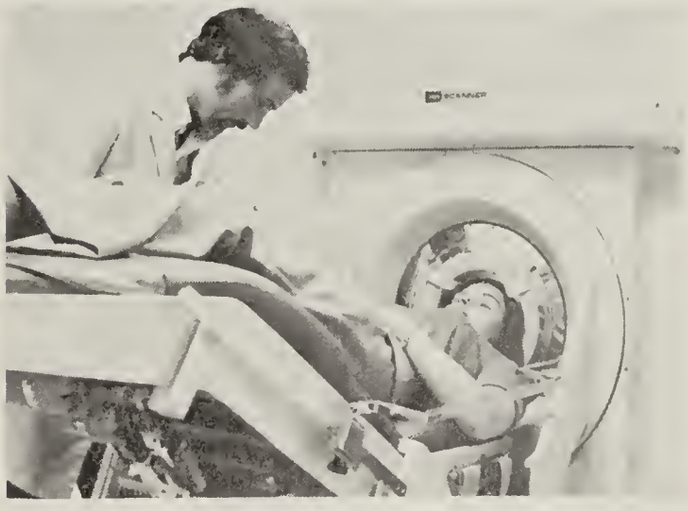
An EMI Scanner is in operation at the University of Mississippi Medical Center.

The new system, the only one of its kind in the state, was purchased with $400,000 from a special appropriation approved by the 1974 state legislature.

Developed by EMI Limited of Middlesex, England, the scanner provides up to 100 times more information than standard x-rays, but no more exposure to radiation.

In less than 30 minutes, with no injections and no discomfort to the patient, two or three trained technicians can complete a cranial examination and have the diagnostic data ready for the physician within minutes.

The EMI system uses a narrow beam of x-rays to scan the brain in a series of 0.8 or 1.3-centimeter slices, with two slices scanned simultaneously. During this time, the machine rotates around the pa-



Jane Westbrook, student in nuclear medicine technology at the University of Mississippi Medical Center, portrays the patient as chief technician Jimmie McDonald prepares her for the brain scan with the new EMI Scanner.

tient's head taking 240 readings of x-ray transmission through the head. These readings are converted to electronic form and fed into the mini-computer which solves 43,000 simultaneous equations for each slice.

X-ray absorption values show up on a cathode ray tube screen and can be examined directly or recorded photographically. The computer also provides a numerical print-out of the data.

State Physicians Attend UMC Seminar



Family physicians from throughout Mississippi discussed special needs of their diabetic patients at a symposium at the University of Mississippi Medical Center. With event faculty member Dr. John A. Colwell, professor of medicine at the Medical University of South Carolina, second right, are, from left, Dr. Preston S. Herring of Vicksburg; Dr. John E. Powell of Houlka; and Dr. Samuel I. Feurst of Vicksburg.

Dr. Hopson Appointed Emergency Director

Dr. William Briggs Hopson, Jr., of Vicksburg has been appointed State Medical Director for Emergency Medical Services of the State Board of Health, according to Wade Spruill, division director.

Dr. Hopson will work with EMS medical directors and physicians in the development of critical care plans for regional EMS systems as they develop, according to Spruill.

Critical care plans include treatment for high risk patients suffering from trauma, cardiac crises, burns, poisonings, alcoholism, drug overdoses, acute psychiatric problems and other high risk emergencies.

Dr. Hopson received his B.S. from the University of Mississippi and his M.D. from the University of Tennessee.

He is co-director and medical consultant for the Warren County Ambulance Service, a member of the EMS Task Force of the Central Mississippi Health Planning Council, chairman of the Ad Hoc Committee for Categorization of Emergency Rooms, president and founder of the state chapter of the American Trauma Society and president of the American Trauma Association.

Dr. Hopson's appointment has been endorsed by the Mississippi Emergency Medical Services Advisory Council.

Medical Center Hosts Tumor Registry Course

Tumor registrars from Mississippi, Alabama, and Louisiana will share resources in a Nov. 17-19 conference at the University of Mississippi Medical Center.

Open to physicians, tumor registrars, and other health professionals who use tumor registries, the three-day session offers 15 American Medical Record Association continuing education clock hours credit.

Faculty will include Mrs. Marjorie Krennerich, American College of Surgeons cancer registry consultant, and two other ACS representatives. Medical Center faculty and staff are also on program.

Mrs. Lorraine Shell, tumor registrar at the Medical Center since 1957, is conference coordinator. Sponsors are the American College of Surgeons; the American Cancer Society, Mississippi Division and Hinds County Unit; and the UMC Division of Continuing Health Professional Education.

No fee will be charged, but advance registration is requested. Enrollment should be addressed to Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

Interagency Council on Smoking Meets

The Mississippi Interagency Council on Smoking, composed of representatives from the health agencies,

University of Mississippi Medical Center, State Board of Health, U. S. Department of Labor, colleges, and news media, held their first meeting of the year in September to develop programs for 1975-76.

Six projects in the areas of education, legislation and quit clinics were proposed. They are: National Education Week on Smoking, Quit Clinics for Youth, Legislation, Investigation of insurance benefits for non-smokers, Quit Clinics for Adults, and a Council newsletter.

Officers of the MICSH are: Mrs. Elizabeth Johnson, American Cancer Society, chairman; Alton Ricks of Copiah-Lincoln Junior College, Wesson, vice-chairman; and Mrs. Martha Monaghan of Mississippi Lung Association, secretary and treasurer.

UM Hypertension Conference Held



Participating in a recent conference at the University of Mississippi on patient compliance with medical regimens in high blood pressure were (from left) Elizabeth Pickett, dietitian, Panola County Health Department in Batesville; Dr. L. G. Hopkins, Oxford physician; Dr. Mickey C. Smith, chairman of Health Care Administration at Ole Miss; and Deon Jones, School of Health Related Professions, University Medical Center, Jackson. Dealing with all aspects of "this real medical problem" of patient compliance, the conference was sponsored by the Department of Health Care Administration in the School of Pharmacy.

Restrictions on FMGs Urged

Representatives of the health industry agreed with Sen. Edward Kennedy, D-Mass., that fewer and better qualified foreign medical graduates (FMGs) should be allowed to practice in this country.

Hearings by Kennedy's Health Subcommittee on health manpower legislation through September 30 cited 1973 American Medical Association (AMA) estimates that there are 71,335 foreign medical graduates or 21 per cent of the physicians practicing in the U. S.

The problem is, Kennedy said, that the qualifying test offered by the Education Council for Foreign Medical Graduates (ECFMG) is totally inadequate and "simply too easy."

And, while 90 per cent of all U. S. medical graduates pass part I and II of the National Board examination, he said it is estimated that only 20 per cent of the foreign graduates could pass them, partly due to English language difficulties.

Kennedy indicated he favors legislation and administrative action limiting the number of FMGs by making those on an exchange visitor visa return home after completing their studies; eliminating the preference status for physicians seeking to immigrate to the U. S.; and strengthening the examination FMGs must take before starting internships, including tough oral and written English tests.

Diabetic Symposium Held at UMC



Dr. Luther B. Travis, professor of pediatrics at the University of Texas Medical Branch, Galveston, center, was a guest faculty member for a University of Mississippi Medical Center diabetes symposium. Participants included Dr. Roland B. Robertson, left, conference coordinator and director of the UMC Division of Continuing Health Professional Education, and Dr. Edmund H. Crane of Gulfport. The UMC Division of Continuing Health Professional Education and the School of Medicine sponsored the course with support from the Upjohn Company.

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Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard anti convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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ORIGINAL PAPERS

The "Half and Half Fingernail": The Most Significant Onychopathological Indicator of Chronic Renal Failure

CARLTON RALPH DANIEL, III,
JOHN D. BOWER, M.D., and
CARLTON RALPH DANIEL, JR., M.D.
Jackson, Mississippi

The populations examined in this study consisted of chronic renal failure patients, chronically ill patients without renal failure, and normals. Each group was examined for the presence of various fingernail abnormalities. It was found that the "half and half fingernail" was seen only in patients with chronic renal failure. However, not all patients with chronic renal failure exhibited the phenomenon (9.4 per cent manifested the abnormality). Furthermore, a chi-square analysis showed that the "half and half nail" was the only manifestation significantly discriminating between chronic renal failure and the other two groups. Therefore, the "half and half fingernail" is a valuable addition to the physician's diagnostic armamentarium, say the authors.

THE ASSOCIATION between onychopathology (diseased fingernails) and disease in general has long been suspected. Hippocrates' classic description of clubbing and Reil's findings in 1792 of pigmented abnormalities following febrile diseases attest to this.[1] Recently, a myriad of fingernail abnormalities have been associated with systemic disease, especially chronic renal failure. William Bean, a pioneer in onychology, has been instrumental in generating this interest. Also, Lindsay,[1] Stewart,[2] Terry,[3] Leyden,[4] and others have contributed to the use of fingernails as diagnostic tools in renal failure, cirrhosis, and other pathological states.

A study was conducted at the University of Mississippi Medical Center to test the utility of various renal onychopathies. Five populations were utilized. 1) Twenty-five patients diagnosed as having chronic renal failure, seen regularly in the kidney clinic, but not on dialysis, composed the first group. 2) Eighty-one chronic hemodialysis patients made up the second. 3) A combination of groups 1 and 2 above was labeled "combined chronic renal failure." 4) A grab sample of 100 individuals was chosen from outside the hospital and labeled as "normal." 5) Last of all, 150 chronically ill patients (non-psychiatric requiring continuing medical care) without renal failure were studied. This group was subdivided into two divisions. Fifty of these patients were hospitalized (Group 5a) and 100 patients were not hospitalized (Group 5b). This differentiation was made for the purpose of indicating the severity of their present condition. The non-hospitalized group was under the long-term care of a local internist.

From the Artificial Kidney Unit, University of Mississippi Medical Center, Jackson, Miss.
Presented before the Section on Medicine, 107th Annual Session, Mississippi State Medical Association, Biloxi, May 7, 1975.

Pigmentation was classified into one of the following groups: normal, crescents present, Mee's lines present, "half and half nail" present, longitudinal pigmentation present, or Muehrcke's lines present. The criteria used to define the previous entities are as follows. A crescent is a "prominent" onychodermal band (red or brown[2]) extending approximately 20 per cent to 25 per cent of the distal portion of the fingernail. In 1953, Terry defined an onychodermal band as a pale reddish band running just proximal to the distal end of the normal nail that was visible only with close scrutiny.[3] Another onychopathy, the "half and half nail," associated with azotemia has previously been described by Bean,[5] Lindsay,[1] and Leyden.[4] Leyden has found by biopsy and substantiation by the Fontana technique, bleaching with hydrogen peroxide, and darkening with silver stain, that the pigment deposited in this abnormality was, in fact, melanin. He further suggests that renal decomposition may account for the stimulation of matrix melanocytes and subsequent pigment formation.[4]



Figure 1. Lower mid portion of photograph shows the fingernail with the crescent. The finger in the upper left illustrates the "half and half nail." The patient has chronic glomerulonephritis.

For the purpose of this study, a "half and half nail" displayed either a white or a normal proximal half and a distinctly abnormal brown portion extending approximately 50 per cent from the distal end proximally. The "half and half nail" and crescent both appear in Figure 1.

The next group consisted of patients having a single white transverse line above the lunula, but well below the distal edge of the nail. This abnormality, Mee's line, classically associated with arsenic intoxication can occur in a number of systemic diseases, including acute and chronic renal failure, pneumonia, Hodgkin's disease, malaria, and myocardial infarction.[6] Another entity was longitudinally pigmented brown bands. Parrish described this group and stated that longitudinal stripes were commonly seen in more heavily pigmented races and most often a non-specific finding.[7] Furthermore, Bissell has held that this phenomenon was noted in primary adrenal insufficiency.[8] Mee's line and longitudinal pigmentation appear in Figure 2. Lastly, Muehrcke's lines or double white transverse lines appearing above the lunula and below the distal edge of the fingernail in hypoalbuminemia[1] and the nephrotic syndrome[4] were included in this study.

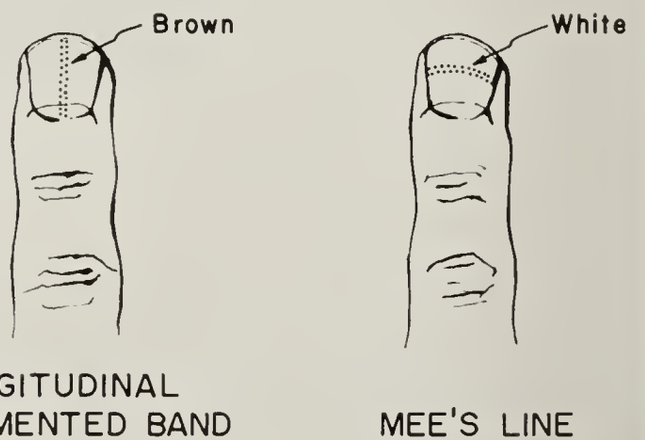


Figure 2. Mee's Line and Longitudinal Pigmented Band.

All subjects were interviewed and their fingernails were examined for normality of pigmentation. Emphasis was placed on the fact that fingers must be completely relaxed and not pressed against any surface. Failure to do either may distort an observation by altering blood flow and changing the appearance of the nail.

TABLE I

CROSS TABULATION OF GROUPS BY ABNORMALITIES PRESENT

	Normal Pigmentation	*Crescent*	*Mee's Line*	*Half and Half*	*Longitudinal Pigmentation*	*Total Individuals*
Normal (group 4)	96	4	0	0	0	100
Dialysis (group 2)	39	29*	4	8*	3	81
Chronic renal failure (group 1)	19	6*	0	2*	0	25
Combined chronic renal failure (group 3)	58	35*	4	10*	3	106
Chronically ill hospitalized (group 5a)	34	16	0	0	0	50
Chronically ill non-hospitalized (group 5b)	84	15	1	0	0	100

* Two individuals with the "half and half fingernail" also have crescents.
No Muehrcke's lines were found.

RESULTS

The distribution of fingernail abnormalities by groups is given in Table I. Examples of each of the onychopathies under study were found, except for Muehrcke's lines. Approximately 9.4 per cent of the patients with chronic renal failure exhibited the "half and half fingernail" while the other groups failed to manifest the phenomenon. A chi-square analysis (significance level = .05) was used to compare the frequencies appearing in Table I (see Table II). It indeed revealed that the "half and half nail" was the most significant finding in chronic renal failure patients.

DISCUSSION

The combined group of chronic renal failure was compared to each of the other groups with respect to the presence or absence of each abnormality. When the combined chronic renal failure group was compared to the normal subjects with respect to the presence or absence of each abnormality, a significant relationship was found for all manifestations, except longitudinal pigmentation. This simply implied that longitudinal pigmentation was the only symptom that could not be used to distinguish between the combined chronic renal failure group and the normals. In fact, longitudinal pigmentation could not be used to differentiate between the combined chronic renal failure or any of the other groups.

When the combined chronic renal failure group was compared to the chronically ill hospitalized group with respect to normal and abnormal pigmentation, presence and absence of crescents, presence and absence of Mee's lines, and presence and absence of "half and half nails," the "half and half nail" was the only symptom that appeared to be discriminating. That is, the proportion of chronically ill hospitalized patients with "half and half nails" differed significantly from the group with chronic renal failure. This was the only symptom that accurately discriminated between chronically ill hospitalized patients and the combined chronic renal failure group.

In addition, it appeared that normal pigmentation, crescents, and "half and half nails" were each discriminatory with respect to the combined chronic renal failure group, and each of the normal and chronically ill non-hospitalized groups. However, the

TABLE II

χ^2 VALUES FOR COMBINED CHRONIC RENAL FAILURE GROUP VERSUS EACH OF THE OTHER GROUPS WITH PRESENCE AND ABSENCE OF EACH MANIFESTATION

	Normal Pigmentation	*Crescents*	*Mee's Line*	*Half and Half*	*Longitudinal Pigmentation*
Normals (group 4)	χ^2= 46.47	28.23	3.85	9.92	2.87
	$p<.005$	$p<.005$	$p<.05$	$p<.005$	N.S.*
Chronically ill hospitalized (group 5a)	χ^2= 2.48	.02	1.94	5.04	1.44
	N.S.	N.S.	N.S.	$p<.025$	N.S.
Chronically ill non-hospitalized (group 5b)	χ^2= 9.72	9.09	1.67	9.92	2.87
	$p<.005$	$p<.005$	N.S.	$p<.005$	N.S.

* N.S. Stands for not significant. Alpha (significance level) =.05. For each significant difference, the "p" value is given.

"half and half nail" was the only manifestation that could accurately distinguish the combined chronic renal failure group from each of these two groups, and also from the chronically ill hospitalized group. The strength of this relationship was evident, not only when one inspected the chi-square statistic, but also by the size of the "P" value associated with each. (See Table II for detailed chi-square analysis.) The "half and half nail" was seen only in patients with chronic renal failure whether on dialysis or not. However, not all patients with chronic renal failure exhibited the phenomenon (9.4 per cent manifested the abnormality).

Various pigmental abnormalities have been associated with chronic renal failure in previous studies. However, for the clinical diagnostician, the "half and half nail" presently seems to be the most specific and relevant onychological finding, and may very well be the pertinent needle in the haystack of associated renal onychopathies. ★★★

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ACKNOWLEDGEMENTS

We would like to thank Dr. Robert Watson and Mrs. J. G. Thomas of the University of Mississippi Department of Epidemiology and Biostatistics for their valuable assistance on this paper.

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DID YOU KNOW?

The crack in the Liberty Bell that tolled on July 8, 1776, to proclaim American Independence, did not appear until it was rung in mourning for Chief Justice John Marshall in 1835. The crack was then drilled out the following year so that the edges would not vibrate against each other. The last time it was to be tolled was on Washington's birthday of that year. Until about noon, the tolling rang out loud and clear. Then, the crack spread, and the ringing changed to a hoarse rumble. The clear voice of the famous bell was never to be heard again.

—*Miss. Bicentennial Newsletter*

Maternal Mortality in Mississippi: 1972

WILLIAM B. WIENER, M.D.
Jackson, Mississippi

A summary of data obtained by the MSMA Committee on Maternal and Child Care from its study of maternal deaths in Mississippi in 1972 is presented. The author reviews the committee's methods of study and the results found.

ANALYSIS OF DEATHS occurring in women during or within 90 days after pregnancy is of continuing value in pointing up ways in which this tragic loss of life can be reduced. The Committee on Maternal and Child Care of the Mississippi State Medical Association has recently compiled its study data for the calendar year 1972. The present report completes the 17th annual study by the committee on maternal deaths occurring in Mississippi. Data collected in a similar manner as before are presented and compared, when appropriate, with those for prior years.

Data from the Mississippi State Board of Health indicates that in 1972 there were 23 maternal deaths. This compares to 31 maternal deaths in 1971. The number of live births in the state totaled 45,907 in 1972 down from 48,601 in 1971. Thus the maternal mortality rate (maternal deaths per 10,000 live births) rose from 4.3 in 1971 to 5.2 in 1972. This represented a white maternal mortality rate of 2.1 for the year and a nonwhite maternal mortality rate of 8.5. The maternal mortality rate for the United States in 1972 was 1.9.

The committee studied 23 maternal deaths occurring in 1972. There was a significant increase in the percentage of usable replies received to the committee's inquiries in 1972 (see Table I). All replies are evaluated according to their adequacy on a scale from 1 (low) to 5 (high) (see Table II). In order to achieve the latter rating the data sheet for the committee's study has to be completely filled out, a relevant explanatory note attached, and an autopsy report included, if available. Cases rated 1 or 2 are often difficult to evaluate because of the scanty nature of the information. The overall quality of the replies received in 1972 was considerably better than in 1971.

Following the AMA "Guide for Maternal Death Studies" the committee classifies maternal deaths as either being direct obstetric deaths or indirect obstetric deaths. Direct obstetric deaths are defined by the Guide as those in which the cause of death is due to a condition directly related to the pregnancy such as hemorrhage, toxemia, infection, anesthesia, or vascular disease. Indirect obstetric deaths are those resulting from disease present before or developing during pregnancy which was not a direct effect of the pregnancy but was obviously aggravated by the physiological effects of the pregnancy and caused the death.

TABLE I

STUDY MATERIAL

	1971		1972	
	No.	*Per Cent*	*No.*	*Per Cent*
Total cases	16		23	
Replies received	14		20	
Replies usable	14	87.5	19	82.6

TABLE II

ADEQUACY OF DATA

	1971		1972	
Category	*No.*	*Per Cent*	*No.*	*Per Cent*
5	0		2	10.5
4	3	21.5	7	36.8
3	9	64.3	5	26.3
2	1	7.1	4	21.0
1	1	7.1	1	5.3

Chairman, Committee on Maternal and Child Care.
Committee members—W. E. Godfrey, M.D., Natchez; George J. Nassar, M.D., Greenwood; K. Ramsay O'Neal, M.D., Hattiesburg; Wendell H. Stockton, M.D., Amory. Consultants—Catherine G. Goetz, M.D., Jackson (Pathology); Alvin E. Brent, Jr., M.D., Jackson (Internal Medicine); Curtis W. Caine, M.D., Jackson (Anesthesiology).

The proportion of deaths considered to be due to the complications of pregnancy itself (direct obstetric deaths) was slightly higher in 1972 when compared to 1971 (see Table III). The cases in which the cause of death could not be determined illustrate the difficulty that the committee has when information is scanty or when the physician has seen the patient only for a short time before death or even after death.

Among the direct obstetric deaths, the percentage due to hemorrhage increased some during the two years studied (see Table IV). In 1957, the first year the committee conducted its studies, 59.2 per cent of the direct obstetric deaths was due to hemorrhage. Deaths due to toxemia decreased during the period studied.

TABLE III

CAUSES OF DEATH

	1971		*1972*	
	No.	*Per Cent*	*No.*	*Per Cent*
Direct obstetric	11	78.6	16	84.2
Indirect obstetric	2	14.3	2	10.5
Undetermined	1	7.1	1	5.3

TABLE IV

CAUSES OF DIRECT OBSTETRIC DEATHS

		1971 Per Cent (of All Deaths Studied)		*1972 Per Cent (of All Deaths Studied)*
	No.		*No.*	
Hemorrhage	4	36.4	1	43.8
Toxemia	4	36.4	1	6.2
Infection	3	27.2	4	25.0
Vascular accidents	0		1	6.3
Anesthesia	0		3	18.7

TABLE V

AVOIDABILITY

	1971		*1972*	
	No.	*Per Cent*	*No.*	*Per Cent*
Avoidable	12	85.8	16	84.2
Non-avoidable	1	7.1	1	5.3
Undetermined	1	7.1	2	10.5

TABLE VI

AVOIDABLE FACTORS

	1971		*1972*	
	No.	*Per Cent*	*No.*	*Per Cent*
Professional	9	56.3	14	73.7
Hospital	1	6.2	1	5.3
Patient	6	37.5	2	10.5
Undetermined	0	37.5	2	10.5

The percentage of deaths considered avoidable by the committee was about the same in both years studied (see Table V). Avoidable factors are arbitrarily assigned to the physician, hospital or patient (see Table VI).

SUMMARY

In an effort to assist personnel in handling difficult cases the revised "Maternal Care Desk Cards" have been distributed to all hospitals. With the decline in births some hospitals have discontinued their obstetrical services and these patients will go to hospitals where facilities for caring for the "high risk" patients are available. The University Medical Center is also giving courses in handling high risk patients. It is hoped that all of the above will help to decrease the number of maternal deaths in Mississippi. ★★★

500-G East Woodrow Wilson (39216)

BICENTENNIAL QUOTE OF THE QUARTER

"To see it in our power to make a world happy—to teach mankind the art of being so—to exhibit, on the theater of the universe, a character hitherto unknown—and to have as it were, a new creation entrusted to our hands, are honors that command reflection and can neither be too highly estimated nor too greatly received."

THOMAS PAINE, 1775

Radiologic Seminar CLVII: Radiological Aspects of Mitral Valve Disease

JOHN Y. GIBSON, M.D.
Jackson, Mississippi

THERE ARE PRIMARILY two alterations of the chest radiograph that are keys to the recognition of mitral valve disease. These are left atrial enlargement and a specific type of abnormal pulmonary vascular pattern. Other factors to be considered are septal lines, ventricular enlargement, the size of the main pulmonary artery and the size of the aortic knob.

The most reliable and consistent signs of left atrial enlargement are prominence of the left atrial appendage and a double density in the region of the left atrium. The left atrial appendage does not normally project beyond the border of the cardiac silhouette in the posteroanterior (PA) projection. When the left atrium enlarges, however, the appendage produces a localized protrusion of the left border of the silhouette below the shadow of the main pulmonary artery (see Figure 1).

Also on a PA view of good technical quality an enlarged left atrium will appear as an oval shaped "double density" within the cardiac silhouette occupying the anatomical area of the left atrium (see Figure 1). Seeing such an area of increased density only within the right side of the silhouette is not reliable since other structures such as the confluence of pulmonary veins can cast such a shadow. The increased density should be identified across the entire area occupied by the left atrium, to the left of the midline as well as to the right, before this sign is reliable as an indication of left atrial enlargement.

A late finding of left atrial enlargement is elevation of the left main stem bronchus. Once the atrium has become large enough to produce this finding, the other signs are usually present. On an esophagram there will be a localized posterior displacement of that portion of the barium filled esophagus adjacent to the enlarged left atrium (see Figures 2 and 3). This is best appreciated on lateral and right anterior oblique views (see Figures 2 and 3).

Normally the vascular pattern is more prominent in the lower half of the lung fields. As pressure increases in the left atrium there is a resultant increase in pulmonary venous pressure and the pulmonary veins in the upper half of the lungs become dilated. Ultimately the vessels in the lower lung fields, both arteries and veins, become constricted. The resultant pattern of more prominent upper than lower vessels is characteristic of the abnormal vasculature seen in patients with mitral valve disease, and is a reversal of that seen in the normal patient (see Figures 1 and 5).

Once the presence of mitral valve disease is recognized by enlargement of the left atrium and the characteristically abnormal vascular pattern, other findings can be used to evaluate the specific type of disease and to some extent the severity.



Figure 1. Pure mitral stenosis with a prominent left atrial appendage (arrow), a faintly visible double density in the region of the left atrium and more prominent upper vessels than lower.

Sponsored by Mississippi Radiological Society.
From the Department of Radiology, University Hospital, Jackson, Miss.



Figure 2. Lateral view of barium filled esophagus displaced posteriorly (arrow) by an enlarged left atrium.

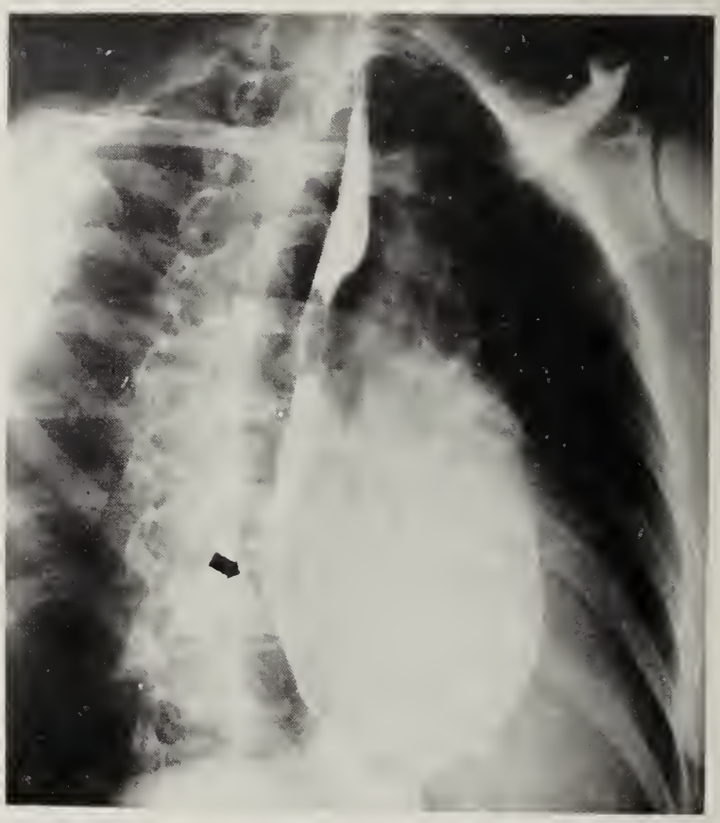


Figure 3. Right anterior oblique view of barium filled esophagus displaced by enlarged left atrium (arrow).

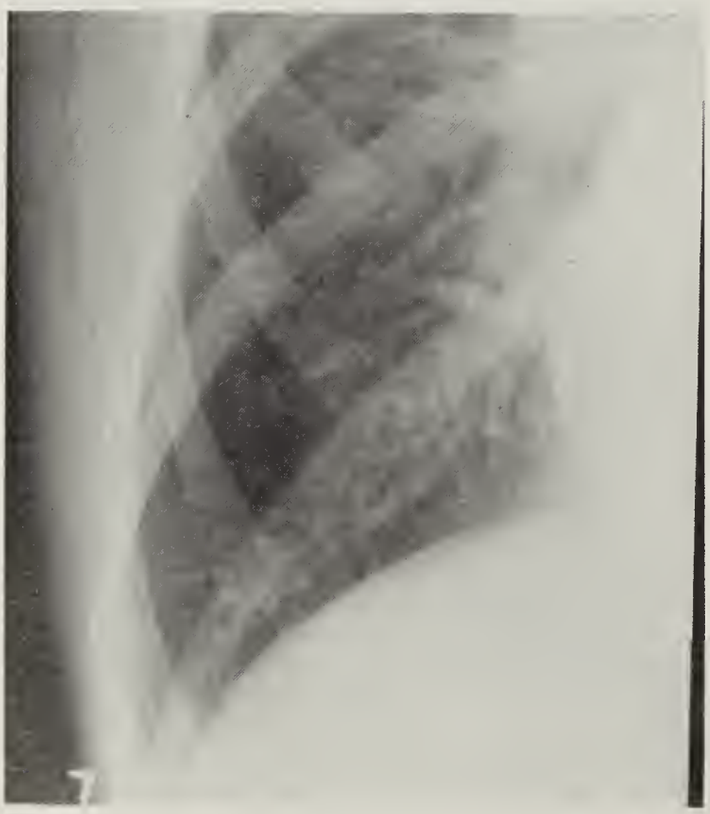


Figure 4. Close-up view showing Kerley B lines in lateral right lung base above costophrenic angle.



Figure 5. Predominant mitral regurgitation with a prominent left atrial appendage (arrow), left ventricular enlargement and a normal main pulmonary artery. Upper pulmonary views are dilated.

Further increase in pulmonary venous pressure causes leakage of fluid into the interstitial spaces. This interstitial edema results in thickening of the interlobular septa which can be recognized radiographically as transverse opaque lines known as Kerley lines after the man who first described them. These septal lines are best seen in the lateral lung bases where they are called Kerley "B" lines (see Figure 4). Less common "A" lines can occasionally be seen radiating from the hilum and rarely "C" lines produce a more diffuse reticular pattern. Such septal lines are more often seen with predominant mitral stenosis than with predominant regurgitation. Kerley lines are not specific for mitral disease but can be seen whenever there is thickening of the interlobular septa from interstitial edema due to any cause or from other causes such as fibrosis.

In pure mitral stenosis the left ventricle does not enlarge (see Figure 1). Increasing pressure in the pulmonary veins will ultimately cause a rise in the pulmonary artery pressure and consequently a rise in the right ventricular pressure. These changes are manifested radiographically by enlargement of the main pulmonary artery and right ventricle. When mitral regurgitation predominates the left ventricle will be enlarged due to volume overload but the pulmonary artery and right ventricle will usually remain normal (see Figure 5). Enlargement of the left ventricle can also be due to associated aortic regurgitation or systemic hypertension.

Specific ventricular enlargement can be determined best from the lateral projection. In this view enlargement of the left ventricle can be recognized by projection of the posterior cardiac border more than 1.5 cm. behind the shadow of the inferior vena cava. Enlargement of the right ventricle produces an increase in the anterior cardiac mass reducing the retrosternal air space. When the cardiac silhouette is enlarged and only the PA view is available, right ventricular enlargement can be inferred by an enlarged main pulmonary artery and left ventricular enlargement by a main pulmonary artery of normal size.

The size of the aortic knob can be an indication of the severity of the mitral disease. In mild or moderate disease the aortic knob will usually be normal in size. In severe disease due to either predominant regurgitation or stenosis the aortic knob will be small because of the reduced cardiac output.

SUMMARY

The initial radiological recognition of mitral valve disease depends upon the demonstration of enlargement of the left atrium associated with a specific pattern of abnormal vasculature where the upper pulmonary vessels are more prominent than the lower. A reasonably accurate assessment of the type and severity of mitral disease can be made by evaluating signs of interstitial edema, specific ventricular enlargement and the size of the main pulmonary artery and aortic knob. ★★★

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The Mississippi Society for the Prevention of Blindness estimates that glaucoma accounts for one out of every seven new cases of blindness. Glaucoma, the second leading cause of vision loss, strikes most often in the 35-years-plus bracket. The society recommends eye exams for people in this age range every two years.

Dr. Samuel Van Dyke: Member First Mississippi State Board of Health

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Corinth, Mississippi

THIS IS THE fifth in a series of articles on members of the first Mississippi State Board of Health which was established in 1877.

Samuel Van Dyke Hill was born at Nashville, Tenn., July 25, 1835, the son of Dr. D. B. Hill and Margaret J. (Stout) Hill.[1] The infant's paternal ancestry was English; his mother was of Dutch descent.[2]

The author, well-known Mississippi historian, gives a brief biography and professional sketch of Dr. Samuel Van Dyke Hill. Among his accomplishments were outstanding service in the Confederate army, positions of leadership in state and national medical organizations, and membership on the first Mississippi State Board of Health.

In S. V. D. Hill's childhood his father moved to Mississippi but authorities differ as to the place, one giving the location as Clay County near West Point[3] while another states: "In his eighth year his father moved the family from Tennessee to Chickasaw County, Mississippi."[4] Here the child was educated in the schools of the area and the Columbus high school.[5]

For his medical education Dr. Hill attended lectures at the University of Louisville and the University of New York where he was graduated in March 1857.[6] Until the Civil War began he practiced at Palo Alto, Mississippi.[7]

In January 1861 Dr. Hill was appointed assistant surgeon in the Confederate army and surgeon in 1863.[8] In the meantime he had married Miss Jennie Calvert of Chickasaw County on Oct. 10, 1861, and she had accompanied him to Virginia.[9]

It is said that the young couple spent part of their honeymoon on the battlefield of Bull Run and that they served together in Kentucky, Virginia and Georgia.[10] According to another source, Dr. Hill

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Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with soecial caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

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Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

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455

was in charge of Quintard general hospital (Richmond) from October 1862 until the end of the war.[11]

At the close of hostilities Dr. Hill was paroled at Meridian, Mississippi. Then he was associated in practice at Macon with Dr. H. A. Minor.[12] Of Dr. Hill's ability as a diagnostician Dr. Minor said: "He was the best I ever had."[13] Dr. Hill is said to have had "a striking and pleasing personality. His head was massive and his features strong. . . . In repose his face showed the student and the thinker."[14]

The career of Dr. Hill included active participation in several medical groups. He was president of the Mississippi State Medical Association, 1870-71. He served as a delegate to the A.M.A. from the state association; also as a delegate to the International Medical Congress, convened in Washington.[15] After Dr. Hill's appointment to the State Board of Health in 1877 he was re-appointed at the expiration of each term of service.[16] He served as vice-president for Mississippi of the Association of Confederate Army and Navy Surgeons.[17]

Among Dr. Hill's published writings are reports on cerebrospinal meningitis and on hypodermic medication. (*Transactions,* Mississippi State Medical Association.)[18]

Dr. Hill died on Oct. 14, 1889, in St. Louis where he had gone for medical treatment.[19] A memorial tribute to Dr. Hill was given by Dr. B. F. Kittrell. *(Transactions,* Mississippi State Medical Association, Jackson, 1890.)[20] A sketch of Dr. Hill appeared in the *Medical Mirror,* St. Louis, 1890 (1-428).[21] ★★★

P.O. Box 7 (38834)

Note: Previous sketches of members of the first Mississippi State Board of Health by this writer were published in this JOURNAL in September 1969, October 1971, and December 1973. They were articles on Dr. James Marcus Taylor, Dr. Anson Gordon Smythe, and Dr. David Lewis Phares. An article on Dr. T. D. Isom appeared in January 1975.

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1. *History of the Mississippi State Medical Association.* 2nd edition. 1949. p. 56.
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6. *Ibid.*
7. *Ibid.* Apparently Palo Alto was in Chickasaw county.
8. *Ibid.*
9. *Ibid.*
10. *Hist. Miss. State Med. Assoc.* 2nd edit. p. 56.
11. *Biog. and Hist. Memoirs of Miss.* Vol. II, p. 284.
12. *Hist. Miss. State Med. Assoc.* 2nd edit. p. 56.
13. *Ibid.*
14. *Ibid.* A photograph of Dr. Hill appeared with this sketch.
15. *Biog. and Hist. Memoirs of Miss.* Vol. II, p. 284.
16. *Ibid.*
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19. *Biog. and Hist. Memoirs of Miss.* Vol. II, p. 284.
20. *Index-Catalogue of the Library of the Surgeon General's Office, United States Army.* Vol. VII, p. 117. Washington 1902.
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Wishing you and yours
a joyous holiday season
and a happy and fulfilling year!
—MSMA staff



The President Speaking

"Vigilance Is the Price of Liberty"

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

IT IS APPROPRIATE in this Bicentennial year to recall these words commonly attributed to Thomas Jefferson. "Eternal vigilance" he said, "is the price of liberty." When I think of those words in the context of the crisis confronting the medical profession, I am reminded that it is not enough to hope that "everything will be alright." To be more precise, it is not enough to wait until professional liability insurance is no longer available and then react to that harsh reality *after* the fact. What is required, in my judgment, is that we anticipate that crisis and plan a response to it before it is upon us. I am glad to be able to report to you that such a sense of vision was present at the called meeting of the House of Delegates held in Jackson on October 23.

In the first place the delegates voted to actively push, by all proper means, a legislative package that will hopefully help to stabilize the medical malpractice climate in Mississippi. By the time these observations appear in print each of you will have received this "legislative package" outlining in some detail each of the several proposals that will be introduced in the legislature this next session. I would urge you to study these proposals carefully and to discuss them with your legislators.

In addition to the legislative package, your House of Delegates instructed your officers and Board of Trustees to proceed with further feasibility studies relative to the formation of a physician member, nonprofit corporation, established to provide professional liability insurance coverage to Mississippi physicians at a reasonable cost. If further studies prove favorable in the areas of need and actuarial and financial feasibility, and if a minimum of 750 members of the Mississippi State Medical Association choose to join for a fee of $1,000.00, the corporation will become a reality.

If I read correctly the mood of the House of Delegates at the called meeting, it was that we do not want to get into the insurance business—we do not wish to compete with free enterprise—we hope very much that remedial legislation proposed in the legislative package will make for a competitive commercial professional liability insurance market in Mississippi but, if we are abandoned by the commercial carriers, or if the premiums become unreasonable and provisions unsatisfactory, we will have a mechanism ready to go. In Jefferson's words, "Vigilance is the price of liberty." ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVI, NUMBER 12
DECEMBER 1975

EDITORIALS

It's Time

Our state medical association delegates in special session recently voted to investigate a self-owned malpractice insurance program. Ours is only one of several states either actually operating such a plan or considering such a solution.

Many delegates at our recent meeting viewed the situation with mixed emotions but when brought to a vote, it passed overwhelmingly.

It seems to this writer that this action will certainly motivate our membership to "clean our own house" as well as campaign actively for favorable legislation.

Against such action, of course, is the question of whether we should be in the insurance business at all.

There are questions also of what legislative changes might be helpful and legal.

A recent attempt in Idaho to limit liability in each case was declared unconstitutional by their courts (state). The decision by the U. S. Supreme Court, to my knowledge, has not been made due to the fact that such an act has not been tested there.

Doctors are better educated than most segments of our society but are notoriously poor businessmen. Generally they are too busy in their profession to be too concerned about the "State of the Union."

This is unfortunate because the very nature of their work affords them the opportunity to communicate with a broad segment of society. Perhaps we represent the very core of "the silent majority."

Generally we support the AMA, AMPAC, our state organization, and county societies financially but leave it to these groups to represent us politically.

We only seem to get motivated when the malpractice situation becomes threatening or Medicaid denies us reasonable compensation for our time.

The greatest threat to us, to our profession, and to our society is bigger and bigger federal bureaucracy and larger and larger federal deficits. Labor, teachers, minorities, welfare recipients, social security recipients and indeed even we demand more and more of the "pie" when in reality this only aggravates the inflationary cycle and results in little good for any segment.

A demand by each of these groups for fiscal sanity and responsible government would do much more for their cause than any transient increase in wages. One small voice in the wilderness creates little excitement but indeed a letter to your congressman has some impact. When have you last expressed an opinion to your congressman or senator?

Our federal deficits have increased each year and probably will amount to 15 per cent this year. Surely a day of reckoning comes and it can't be far off.

Our system of government cannot survive this situation indefinitely. I am not only concerned but frightened. We are surely courting disaster.

Our complacency must be due in part to the fact that never before in history have so many enjoyed so much of the creature comforts. It seems difficult to arouse a man who enjoys a full stomach, a warm bed and enough to indulge his interests and hobbies.

W. Moncure Dabney, M.D.
Editor
Crystal Springs, Miss.

NEW MEMBERS

ADEN, WILLIAM M., Jackson. Born Vicksburg, Miss., Dec. 6, 1944; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1970; interned Mississippi Baptist Hospital, Jackson, Miss., one year; ophthalmology residency, Baylor College of Medicine, Houston, Tex., 3 years; ophthalmology pathology residency, same, 6 months; elected by Central Medical Society.

GONZALEZ, SERGIO, Laurel. Born Leon, Spain, Sept. 19, 1939; M.D., Tulane University School of Medicine, New Orleans, La., 1967; interned, same, one year; pathology residency, Charity Hospital, New Orleans, La., 3 years; elected by South Mississippi Medical Society.

LEE, ROBERT C., Corinth. Born Pams, Tenn., April 13, 1943; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1968; interned Methodist Hospital, Memphis, Tenn., one year; radiology residency, same, 3 years; elected by Northeast Mississippi Medical Society.

MORRIS, GLENN F., Jackson. Born El Dorado, Ark., Oct. 7, 1946; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1973; interned, same, one year; elected by Central Medical Society.

SANDERS, HARVEY C., Jackson. Born Hollandale, Miss., Aug. 24, 1934; M.D., Loyola University Stritch School of Medicine, Maywood, Ill., 1959; interned Cook County Hospital, Chicago, Ill. one year; general surgery, same, five years; thoracic surgery residency, University of Michigan Hospital, Ann Arbor, Mich., two years; elected by Central Medical Society.

WILKERSON, GEORGE E., Hattiesburg. Born Jackson, Miss., Sept. 24, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1967; interned Hillcrest Medical Center, Tulsa, Okla., one year; psychiatry residency, University of Miami, Miami, Fla., one year; psychiatry residency, University Medical Center, Jackson, Miss., two years; elected by South Mississippi Medical Society.

POSTGRADUATE CALENDAR

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers a series of intensive refresher courses designed to meet physicians' clinical practice needs in the specialties most requested. Mississippi Regional Medical Program partially supports the series which is open to all physicians regardless of race, creed, color, religion, sex, age, or national origin.

Intensive courses are eligible for the American Medical Association Physician Recognition Award Category I credit. Enrollment is limited, and applications are accepted in the order received. Cost is $25.00 per day or $125.00 per week, depending on the course length.

INTENSIVE COURSE CALENDAR

Jan. 12-16, 1976
EKG
Jan. 26-30, 1976
NEPHROLOGY
Feb. 23-25, 1976
UROLOGY
Mar. 3-5, 1976
ENT
Mar. 18-20, 1976
NEUROLOGY/NEUROSURGERY
Mar. 22-26, 1976
PEDIATRICS
April 5-9, 1976
PULMONARY MEDICINE
April 19-23, 1976
NEPHROLOGY

FUTURE CALENDAR

Jan. 30-31, 1976
AMERICAN COLLEGE OF PHYSICIANS REGIONAL MEETING
Mar. 11-13, 1976
SURGICAL FORUM III
Mar. 24-27, 1976
AMERICAN COLLEGE OF PHYSICIANS HEMATOLOGY/ONCOLOGY CONFERENCE
April 13, 1976 (tentative)
THE MISSISSIPPI THORACIC SOCIETY MEETING
April 27-28, 1976
EMERGENCY CARE COURSE FOR PHYSICIANS
May 3-6, 1976
MISSISSIPPI STATE MEDICAL ASSOCIATION

Book Reviews

The Five Year Research and Development Agendum for Ultrasound Imaging Diagnostic Instrumentation. Chevy Chase, Maryland: Alliance for Engineering in Medicine and Biology, 1975. Paperback.

This final technical report provides an ordered list of recommended research and development objectives in medical ultrasound for the next five years. The priority list was derived from recommendations made by four task groups: (1) Interaction of ultrasonic energy with biological structures; (2) Ultrasonic transducers: signal detection and preprocessing; (3) Ultrasonic diagnostic scanning and display systems; and (4) Signal processing. Each task group studied, discussed and made recommendations on a particular topic and issued reports previously; these reports were reprinted as background information. The task groups were composed of experts in the field of medical ultrasound—physicians, scientists, industrial representatives and government affiliated personnel.

This report is of minimal practical usefulness to the medical practitioner since it is concerned with research and development and intended primarily for federal funding agencies, and others involved in ultrasound research and development. If the priority list of research and development objectives is followed, one would expect upcoming research to focus on study to clearly define and prove whether there is *any* risk to the patient from the use of ultrasound in medical diagnostic procedures. Equipment development would center around multiple transducer arrays, linear and two dimensional systems, which would allow "real time" ultrasonic viewing. This would enable production of three dimensional imaging of cardiac motion, quantitative transcutaneous measurement of blood flow and others. While the recommended objectives of research and development are of passing interest and future possibilities for equipment design are fascinating, the book is of little, if any, current practical value for the physician/technologist team engaged in ultrasound imaging studies or beginning in this field.

KENNETH G. CARTER, M.D.
Jackson, Miss.

Emergency Department Organization and Management: American College of Emergency Physicians. Edited by A. L. Jenkins, M.D., with 17 Associate Editors and 39 Contributors. 270 pages with 17 illustrations. St. Louis: The C. V. Mosby Company, 1975. $14.50.

This book was written in order to improve emergency medical services and as a guidebook for emergency physicians, hospital administrators, medical staffs, and others interested in the organization and management of an emergency department. It was planned so that it would serve all types and sizes of hospitals which have active emergency departments and are involved in emergency care and disaster planning.

Topics discussed are not only those which deal with the physical plant, staffing, and the general management of an emergency department, but with intrahospital relationships, community resources and involvement as well as legal and financial aspects of emergency medicine. In addition, the appendixes contain model contracts, bylaws, rules and regulations, and capability standards for emergency department. Sample forms of admission charts, ambulance run slips, suspected rape, child abuse, transfer and release, as well as consent forms for operation and/or treatment are illustrated.

Although discussion of triage, visitor discipline, and some information concerning patients' return visitations and holding areas for patients were not included in the text, I believe some information on these topics would have enhanced the overall value of the book. This is especially true since many emergency departments of necessity serve also as chronic outpatient clinics.

The information offered is concise and presented in such a manner as to be easily understood by all.

This textbook is recommended to anyone interested in emergency department planning and operation, and would be a worthwhile addition to any hospital library.

STEVE C. LEIST, M.D.
Clarksdale, Miss.

DEATHS

RAYBURN, C. W., Pontotoc. Born Oakville, Tenn., Jan. 8, 1917; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1941; interned Gorgas Hospital, Canal Zone, one year; emeritus member of MSMA and AMA; died Aug. 25, 1975, age 58.

SUTTLE, WILLIAM M., Jackson. Born Noxapater, Miss., May 8, 1922; M.D., Tulane University School of Medicine, New Orleans, La., 1953; interned Mississippi Baptist Hospital, Jackson, Miss., one year; died Oct. 21, 1975, age 53.

Medico-Legal Briefs

RESTRICTIONS IN MISSOURI ABORTION STATUTE UPHELD

Provisions of an abortion statute which defined viability, required the woman's informed consent or that of her spouse or parent (if a minor) and prohibited saline abortions after the first trimester were upheld by a federal trial court in Missouri.

Two physicians and a planned parenthood organization brought an action to enjoin enforcement of the Missouri abortion statute. The federal trial court said that the law conformed in all respects but one with the guidelines set down in the U. S. Supreme Court's abortion decisions.

One provision in the abortion law was invalid. That was the provision which prescribed the standard of care that a physician performing an abortion must exercise to protect the fetus. The provision was too broad because it did not exclude the stage of pregnancy prior to viability of the fetus, the court said.

Viability was defined in the statute as the stage of fetal development when the fetus could survive outside the womb by natural or artificial life-support systems. The legislature could not properly fix viability at an inflexible point in gestation, the court said. Viability varies with each pregnancy and the determination must be made by the attending physician.

Requiring informed consent of the women before an abortion was valid since the ultimate decision to have an abortion was hers to make. The informed consent requirement did not single out abortions for special treatment since it was common for most medical procedures, the court noted. Similarly, the requirement for parental consent for a minor was common to all surgical treatments, not just abortions. That requirement and the one requiring consent of a spouse were valid. The compelling interest of the state in protecting the mutuality of the marriage relationship justified the spousal consent requirement.

A live child born from an attempted abortion became an abandoned ward of the state under the abortion law. The rights of the parents consenting to the abortion were terminated. The state was justified in assuming immediate temporary custody of the unwanted child to care for it and preserve its life, the federal trial court said. The abortion statute incorporated another statute giving the parents an opportunity to be heard, thus protecting their due process rights, the court continued. The court also upheld the requirement that live births should be reported to the juvenile court. In addition it upheld a provision requiring maintenance of abortion records as being essential to the advancement of medical knowledge.

Finally, the court upheld the prohibition on the saline method of abortion after the first trimester. The saline method presented a serious threat to the health of the woman. Safe alternative methods such as prostaglandin injections and mechanical means of inducing abortions were less dangerous, the court concluded.

One dissenting judge would have held invalid the requirement of spousal consent, parental consent for a minor, termination of parental rights if the child is born alive and the ban on saline abortions.—*Planned Parenthood of Central Missouri v. Danforth,* 392 F.Supp. 1362 (D.C., Mo., Jan. 31, 1975)

PERSONALS

TEMPLE AINSWORTH, JOEL ALVIS and WAFFORD MERRELL of Jackson announce the relocation of their offices to 500-C East Woodrow Wilson under the name of Urology Associates of Jackson, P.A.

JAMES F. ARENS of Jackson and UMC has been elected to a 4-year term on the American Board of Anesthesiology. He was the only new member elected to the 12-member board during the group's annual meeting.

JARE BARKLEY of Gulfport announces the association of ARTHUR SPROLES for the practice of general-thoracic-vascular surgery at 611 Broad Avenue.

HELEN B. BARNES of Jackson and UMC attended

the Planned Parenthood World Population national medical committee meeting in New York and met with the FDA ob-gyn committee in Washington, D. C.

Richard C. Boronow of Jackson and UMC attended the Society of Pelvic Surgeons scientific sessions in Boston.

Guy D. Campbell of Jackson was elected to the Board of Regents at the annual meeting of the American College of Chest Physicians.

Carlos M. Chavez of Jackson was initiated ACCP governor for Mississippi at the Anaheim conference which Joe R. Norman of Jackson also attended.

Quinton H. Dickerson, Arthur Jones and James L. Crosthwait of Jackson were guest speakers at the Mississippi Heart Association-sponsored seminar for nurses, "Hemodynamic Monitoring with Swan-Ganz Catheter," held in Jackson. The welcome was given by William H. Rosenblatt.

Mable T. Garner announces the opening of her office on Main Street in Fayette for the practice of medicine.

Thomas Clay Hammack has been named coordinator of Medical Services at Ellisville State School.

Richard Hollis of Amory was invited by Vice President Nelson Rockefeller to participate in a Presidential Public Forum on Domestic Policy Oct. 29 in Tampa, Fla.

Robert L. Iacullo has joined the staff of the Smith County General Hospital and has opened an office for the practice of medicine in Taylorsville.

Roy A. Kelly, Jr., has associated with Julian Wiener of Jackson for the practice of urology at 514-F East Woodrow Wilson.

Myron W. Lockey of Jackson and UMC was guest speaker at the Kentucky State Medical Association and Kentucky Eye, Ear, Nose and Throat Association conventions in Louisville.

Richard C. Miller of Jackson and UMC gave a postgraduate course at the American College of Surgeons meeting in San Francisco.

Don O. Mitchell has associated with The Mississippi Allergy Clinic, P.A., for the practice of allergy and immunology at 940 North State Street in Jackson.

Paul H. Moore of Pascagoula has been appointed to a national subcommittee on nuclear medicine which advises the Department of HEW.

Emmett C. Neill of Vicksburg has announced his retirement from the private practice of medicine, which was effective Oct. 30, 1975.

Michael Ong has associated with the Rush Medical Group in Meridian for the practice of hematology-oncology.

Jeanette Pullen of Jackson and UMC attended a National Cancer Institute Symposium on the epidemiology of cancer in Boston.

Thomas Purvis and Basil Trunzler of Natchez have been elected to the Board of Trustees of Natchez Community Hospital.

John E. Rawson of Jackson and UMC is serving as Mississippi's 1976 March of Dimes state chairman.

Donald M. Sherline of Jackson and UMC met with the Committee on Neonatal Resuscitation Film in Chicago.

Dempsey Strange of Starkville has been appointed a member of the Commission on Hospital Care by Governor Bill Waller.

James F. Suess of Jackson and UMC went to Kiev-Moscow, Russia, during October for the Soviet-American Conference on Psychiatry and Human Behavior.

Raul E. Valenzuela of Jackson and UMC attended the Neuro-Ophthalmology Conference in Baltimore.

William C. Warner of Jackson received the Mississippi State University Alumni Association's Distinguished Service Award during the MSU Homecoming activities. Dr. Warner is currently president of the MSU Medical Alumni Association.

Horace C. Watkins, III, and William W. Mayers of Laurel and W. Douglas Godfrey, Tom Louis, III, Kenneth Reed and J. George Smith, all of Jackson, have been named Fellows of the American College of Surgeons.

H. Thurston Whitaker has associated with Jones Weldon Lamb of Greenwood for the practice of medicine and surgery at 405 River Road.

LETTERS

SIRS: Every year sporadic cases of meningitis caused by *Neisseria meningitis* occur in Mississippi. During the past 5 years, an average of 14 cases per year have been reported to the State Board of Health. The utility of chemoprophylaxis to prevent secondary cases among close contacts is a frequent topic of discussion among medical experts. Little good data exist on which to compare the risk of infection, the efficacy and danger of chemoprophylaxis. Studies by the CDC in 1974 and 1975 estimate the sporadic attack rate from Jan. 1-April 30, to be about 0.20/100,000. Five of the 449 (1.1 per cent) case households investigated had a second case of meningococcal meningitis. The 449 households contained a total of 1,364 persons (excluding the index case) for a secondary attack rate of 366/100,000; approximately 1,800 times the baseline attack rate observed in this study. Although the numbers are quite small, they suggest that household contacts are at greater risk of developing meningococcal meningitis than the general population.

Pending additional evidence, the Bureau of Disease Control, Mississippi State Board of Health, recommends that the management of "close contacts" of persons with meningococcal meningitis should include chemoprophylaxis. In general, "close contacts" are persons who live (eat and/or sleep) in the same home as the patient, or young children in the same unit of a nursery or day care center as the patient. Hospital and school contacts are not at increased risk of infection and do not require chemoprophylaxis. Chemoprophylaxis should *not* be postponed until the antibiogram results are known but should be given as soon as the diagnosis is made. The drug of choice is rifampin:

adults—600 mg P.O. every 12 hours for 4 doses
children—10 mg/kg (not to exceed 600 mg) P.O. every 12 hours for 4 doses
infants (3-12 months)—5 mg/kg P.O. every 12 hours for 4 doses

Minocycline appears equally effective but frequent vestibular side effects (dizziness, vertigo, nausea and vomiting) make it a less satisfactory alternative. When used, minocycline is given over a 3 day period:

adults—200 mg P.O. initially then 100 mg P.O. every 12 hours for 5 doses
children and infants (3-12 months)—4 mg/kg (not to exceed 200 mg) P.O. initially then 2 mg/kg (not to exceed 100 mg) P.O. every 12 hours for 5 doses

Sulfadiazine is not an acceptable chemoprophylactic agent unless the organism is known to be sulfa sensitive. One of four recent isolates from Mississippi patients which were tested for sulfadiazine sensitivity was resistant.

All cases of meningococcal meningitis should be reported promptly to the local health department. The organism should be submitted to the State Board of Health for serotyping so that serospecific vaccines, when available, can be rationally used in our state. If and when a case occurs in an institutional setting (day care center, school, prison, etc.) the local health department and the Bureau of Disease Control (Phone: 354-6650) should be consulted to develop appropriate prophylactic measures.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

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MSMA House Convenes In Special Session

For the second time in the past 10 years, the MSMA House of Delegates met in a Special Session. In this instance it was an Oct. 23, 1975, meeting in Jackson to consider the professional liability insurance crisis' effect on Mississippi. In December of 1965 the House met to consider implementation of the Medicare and Medicaid programs.

Matters before delegates at the recent meeting included a "Malpractice Legislative Program" and a report concerning the declining national and state professional liability insurance market to include alternatives to the present market.

Delegates approved an extensive legislative program for introduction during the 1976 Regular Session of the Mississippi Legislature and gave the go-ahead for the Board of Trustees to study and, if certain conditions occur, to establish a nonprofit, physician membership corporation to provide a program of medical liability risk retention and education for MSMA members.

The "Malpractice Legislative Program" which will be mailed to each member of the association so that it may be discussed with their legislators includes proposals: (1) to give the State Board of Health authority to restrict physicians' licenses for professional incompetency; (2) to establish malpractice screening panels composed of physicians, members of the public, and an attorney, to review and resolve medical claims prior to a suit being filed; (3) to provide a "legal shelter" for peer review activities; (4) to statutorily define "informed consent" and the "locality rule"; (5) to reduce Mississippi's present six year statute of limitation on malpractice claims to two years; (6) to permit evidence regarding collateral resources in malpractice suits; (7) to waive the medical privilege in malpractice suits; and (8) to give the Commissioner of Insurance standby authority to establish a Joint Underwriting Association should malpractice insurance become unavailable in the state.

The Board of Trustee's report to the House of Delegates on the declining national and state professional liability insurance market included recommendations that the association examine alternatives to the present market now instead of when a crisis occurs as in other states. The House of Delegates approved the Board's report.



Delegates pay rapt attention as possible solutions to the malpractice insurance crisis are discussed at the special session.

Delta Medical Society Meets

The semi-annual meeting of the Delta Medical Society was held on Oct. 8 at the Bank of Ruleville. Participants on the program were Dr. Boyd Shaw of Jackson, who spoke on the Practical Approach to Blood Gases; Dr. Henry B. Tyler of Jackson, who spoke on Recent Trends in Surgical Treatment of Coronary Artery Diseases; and Dr. Jack Pigott of Memphis, who discussed The Breast Cancer Problem. Also on the program was Dr. Jack A. Atkinson, MSMA president.

ORGANIZATION / Continued

Officers of the five-county Delta Medical Society are: Dr. R. N. Hurt, Indianola, president; Dr. T. J. Barkley, Belzoni, president-elect; Dr. Walter Rose, Indianola, secretary-treasurer; and county vice-presidents: Dr. Arthur Lindsey, Bolivar County; Dr. Arthur Wood, Humphreys County; Dr. Fred Sandifer, Jr., Leflore County; Dr. Virginia Tolbert, Sunflower County; and Dr. John C. Suares, Washington County.

TB Patients Will Be Treated at McComb

The current management of tuberculosis indicates that the majority of tuberculosis patients can be adequately managed on an outpatient basis, and patients requiring hospitalization can be effectively treated in selected general hospitals, according to Dr. Alton B. Cobb, State Health Officer.

Effective Nov. 15, 1975, cases of diagnosed or suspected tuberculosis, residing in the counties listed below, who require hospital care, will be hospitalized at the Southwest Mississippi Regional Medical Center in McComb instead of the Sanatorium: Adams, Amite, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, Wilkinson.

The Southwest Mississippi Regional Medical Center is located at 215 Marion Drive, McComb, telephone no. 684-7361.

Dr. John D. Morgan will function as the Medical Consultant for the program and hold a regularly scheduled tuberculosis clinic at the Pike County Health Department. Dr. Morgan has had training in pulmonary disease, practices in McComb, and is a staff member of the Southwest Mississippi Regional Medical Center. A Public Health Nurse Coordinator will be assigned to the program and will have an office at the hospital. She will serve as a liaison between the hospital and county health departments in Public Health District IX.

Dr. Morgan will be available for telephone consultation regarding cases of diagnosed or suspected tuberculosis who may need hospitalization. He may be reached at telephone no. 684-7721.

Patients needing hospitalization should be referred to the county health department for preparation of the necessary forms and arranging for admission to the Southwest Mississippi Regional Medical Center. The regular Sanatorium admission form will be used until a permanent form can be developed. However, the Board of Supervisors guarantee of payment is not needed since hospital costs will be paid by the State Board of Health. The admission form, a copy of the patient's record, and chest x-rays should be sent with the patient to the hospital.

While it is anticipated that many tuberculosis cases can be managed on an outpatient basis, hospitalization should be considered for: 1) patients too ill to be treated on an outpatient basis; 2) patients for whom a diagnosis cannot be readily established; 3) patients without an acceptable outpatient treatment plan; 4) patients needing re-treatment therapy and close observation for possible toxic effect of second line anti-tuberculosis drugs.

Patients will be discharged to the care of their private physician or the county health department. Dr. John Morgan will hold a monthly tuberculosis clinic at the Pike County Health Department where patients may be referred from Amite, Lawrence, Lincoln, and Walthall counties. A monthly clinic will also be held at Adams County Health Department for patients living in Adams, Franklin, Jefferson, and Wilkinson counties. Patients with suspected tuberculosis may be referred to these clinics for diagnosis and treatment. If hospitalization is indicated, the patient will be referred to the Southwest Mississippi Regional Medical Center as set forth above, said Dr. Cobb.

The program is intended to further unify and strengthen tuberculosis control in Mississippi. It is being directed through the State Board of Health, Tuberculosis Control Unit, and has the support and involvement of the University Medical Center, Mississippi State Sanatorium, and the Mississippi Lung Association. Chest consultants will visit the Southwest Mississippi Regional Medical Center on a regular basis to provide consultation.

Questions concerning this program may be directed to the Tuberculosis Control Unit of the State Board of Health, telephone no. 354-6663 or county health departments.

History of Medicine Society Meets

The History of Medicine Society held its fall dinner meeting on Nov. 13 at the Medical Alumni House on the UMC campus.

Guest speaker was Dr. Julius Cruse, professor, department of pathology, director of graduate studies program in pathology, and associate professor of microbiology at UMC. Dr. Cruse spoke on milestones in the history of immunology.

1976 MSMA-Robins Award Is Announced

The fifteenth annual Mississippi State Medical Association-Robins Award for outstanding community service by a state physician has been announced to the component medical societies by the Board of Trustees. The 1976 award will be presented at the 108th Annual Session during closing ceremonies on May 6.



MSMA-Robins Award

Dr. Jack A. Atkinson, president, and Dr. James O. Gilmore, chairman of the Board of Trustees, said that each component medical society has been invited to submit a nomination for the honor. The award is cosponsored annually by the association and the A. H. Robins Company of Richmond, Va., a long-established manufacturer of ethical pharmaceuticals.

Drs. Atkinson and Gilmore said that nominees must be members of the state medical asociation and that the community service recognized by the local society's nomination must be apart from purely professional attainment, since suitable awards in this connection already exist.

Generally, the service by the physician-nominee should have benefitted the local or state communities in a civic, cultural, or general economic sense. It need not, however, have been a single achievement, since many outstanding citizens contribute to community betterment through a series of services in varying leadership roles.

Nominations should be made by letter, and there are no restrictions upon length or attached exhibits which assist in establishing the nominee's qualifications and record of achievement. Drs. Atkinson and Gilmore said that each letter of nomination must be signed by an officer of the component medical society. Nominations from previous years may be resubmitted.

Deadline for submission of nominations to the state medical association is Jan. 1, 1976. Each nomination will be acknowledged, and the Board of Judges, consisting of the three MSMA vice presidents, will review the nominations.

The Robins series was instituted in 1962, and the award consists of a sculptured bronze plaque in bas-relief, engraved, and mounted on a mahogany panel.

The 14 Mississippi physicians who have received the high honor are Dr. Thomas G. Ross of Jackson, nominated by the Central Medical Society in 1962; Dr. Frank M. Davis of Corinth, by the Northeast Mississippi Medical Society in 1963; Dr. Howard A. Nelson of Greenwood, by the Delta Medical Society in 1964; and Dr. Maura J. Mitchell of Ellisville, by the South Mississippi Medical Society in 1965.

Dr. J. T. Davis of Corinth, by the Northeast Mississippi Medical Society in 1966; Dr. Frank M. Acree of Greenville, by Delta Medical in 1967; Dr. W. H. Anderson of Booneville by Northeast in 1968; Dr. Omar Simmons of Newton, by the East Mississippi Medical Society in 1969; Dr. W. J. Aycock of Calhoun City, by the Northeast Society in 1970; Dr. Walter H. Rose of Indianola, by Delta Medical in 1971; Dr. Reginald P. White of Meridian, by the East Mississippi Medical Society in 1972; Dr. W. A. Long, Jr., of Jackson, by the Central Medical Society in 1973; Dr. Virginia S. Tolbert of Ruleville, by Delta Medical Society in 1974; and Dr. Thomas M. Davis of Jackson by Central Medical Society in 1975.

Dr. Hoyt Gardner Speaks at University Med Center



Dr. Hoyt D. Gardner of Louisville, Ky., president of the Kentucky Medical Association and a member of the AMA Board of Trustees, was featured speaker at the Nov. 7 Center Assembly at University Medical Center in Jackson. Dr. Gardner spoke to medical center staff and employees on national health insurance and the activities of the AMA. He is a general surgeon who received his M.D. degree from the University of Louisville.

AMPAC Exceeds All-Time High

For the eighth straight year, the American Medical Political Action Committee has exceeded its all-time high membership record. In addition, AMPAC has broken its all-time high sustaining membership record.

According to the Nov. 3 AMPAC Bulletin, thus far in 1975, 14 state political action committees have established new all-time high membership records. Those states are Alaska, Arizona, California, District of Columbia, Florida, Georgia, Illinois, Maryland, Mississippi (MPAC), Nevada, New Jersey, South Carolina, Tennessee and Texas.

AMPAC also announced that there are more women members in 1975 than there have been in any previous year since AMPAC's inception. The states which contributed to this achievement by their successful family membership schedules are Arkansas, Georgia, Illinois, Indiana, Kentucky, Maryland and Mississippi. In each of these states, between 40 and 50 per cent of the total membership is made up of women members.

MSMA Auxiliary Supports UMC Children's Hospital



The Woman's Auxiliary to the MSMA made a $600.00 contribution to the University Medical Center Children's Hospital during the recent Workshop held in Jackson. Mrs. J. Edward Hill of Hollandale, at left, WA/MSMA president, presented the check to Ole Miss Vice Chancellor and Medical School Dean, Dr. Norman Nelson. Mrs. W. A. Brown, Jr., of Mathiston, Auxiliary president-elect, assisted with the presentation.

EKG's Studied at Medical Center



Family physicians from four states took intensive refresher training in electrocardiography at the University of Mississippi Medical Center in Jackson. Participants who studied basic EKG techniques and advances in instrumentation included, from left, Dr. H. F. Campbell, Wiggins; Dr. Lloyd LoCascio, New Orleans, La.; Dr. Robert Hackman, Murfreesboro, Tenn.; Dr. Kelly S. Segars, Iuka; and Dr. M. J. Fitzgerald, Demopolis, Ala. The UMC Division of Continuing Health Professional Education sponsored the week-long session with Mississippi Regional Medical Program support.

Physicians, Clergy Meet at UMC

Physicians and clergymen will explore their potential for complementary health care delivery in a Dec. 9 meeting at the University of Mississippi Medical Center.

The workshop meeting is part of an RMP project grant to the UMC Department of Family Medicine to develop and define a role for clergymen counselors as a resource for comprehensive patient care in Mississippi.

University Hospital Department of Pastoral Services and the Mississippi Religious Leadership Conference cosponsor the program with funding from Mississippi Regional Medical Program.

Additional information is available from Special Services, University Medical Center, 2500 North State Street, Jackson, MS 39216.

Jeff Davis County Needs More M.D.s

Medical doctors desiring to locate in Jeff Davis County will be guaranteed a gross annual salary of $50,000.00 per year by the county and be provided a rent free clinic for one year if necessary.

The announcement came at a recent community meeting attended by more than 30 persons. The meeting was called for the purpose of securing new doctors for the county. Many of those attending were unable to find standing room.

The Chamber of Commerce assumed responsibility for greeting prospective physicians and acquainting them with the area.

A motion was also made and passed to ask legislators to increase the number of students in the state's medical school so that there will be enough physicians to serve all areas of the state, and to increase the family services part of the school. A group of persons was designated to contact legislators in regard to the matter.

Aflatoxin Is Studied at Medical Center

The aflatoxin believed to have contaminated some of the Midwestern corn reserves earlier this month is one of the 10 mold-produced toxic substances under study at the University of Mississippi Medical Center.

Aflatoxin is one of 100 known harmful compounds (or mycotoxins) produced by food molds.

Dr. Wallace Hayes, associate professor of pharmacology at UMC, has a five-year grant from the Public Health Service, Department of Health, Education, and Welfare, to study 10 of these toxic substances.

"Earlier studies have shown that mycotoxins can produce liver or kidney disease, cancer, or birth defects in laboratory animals from mice up to monkeys," Dr. Hayes said. "And there's strong circumstantial evidence that aflatoxin may cause cancer in man."

Dr. Hayes will give day-old rats the toxic compounds and watch the deterioration processes closely. He'll also look at cell changes after the introduction of the mycotoxins, but before cancer cells appear.

"Even though we have identified a number of mycotoxins, we still don't know why some molds produce them any more than we know why similar molds make penicillin," Dr. Hayes said.

Dr. Hayes' study will be among the first to examine second generation effects of certain mycotoxins and to investigate how the substances affect living organisms when induced in combination with one another.

"There's been a wealth of research on food additives or chemical compounds which might produce cancer, but very little on the environmental carcinogens," Dr. Hayes said.

Widespread interest in the mycotoxins began a little more than a decade ago, when scientists discovered that aflatoxin-contaminated peanuts were responsible for thousands of turkey deaths in England.

Med Center Hosts AOA Visiting Professor



Dr. Howard Spiro, professor of medicine at Yale University School of Medicine and Alpha Omega Alpha visiting professor to the University of Mississippi Medical Center, talks with UMC senior Max Taylor. The Medical Center ΑΩΑ Chapter, which Taylor serves as president, is among 15 honor medical societies selected to host visiting professors this year. While in Jackson, Dr. Spiro lectured and met informally with UMC faculty and students and addressed the Jackson Academy of Internal Medicine. Author of the widely-used textbook Clinical Gastroenterology, *he has been chief of the Yale medical school gastroenterology section since 1955.*

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Medicare Fee Carving Opposed

Quick action has been urged in a report of the House Ways and Means Health Subcommittee staff to block rollbacks in Medicare reimbursement rates for physicians during the current fiscal year.

Charging that the HEW department's index for calculating reimbursement has had the "unintended and unanticipated effect" of pushing some current payment levels below those of last year, the report said that Congress will have to move quickly "in order to make it as administratively feasible as possible to modify the current situation."

The subcommittee, headed by Rep. Dan Rostenkowski (D-Ill.), has voted tentative agreement on amending the index "so as to preclude any rollback of fiscal year 1976 prevailing fees below fiscal year 1975 prevailing fees." The proposed index uses fiscal year 1973 fees.

In a staff document, the Ways and Means Subcommittee noted that the economic index for physicians' fees was not issued by HEW until last April, almost two and a half years since the enabling legislation was passed. Only 30 days were then allowed for comment from interested parties. "It should be pointed out that if HEW had not delayed so long in implementing the regulations, there would not have been any rollbacks in prevailing charges," the report said.

One of the major criticisms levelled at the rollback by the subcommittee staff was the effect on physician acceptance of assignment under Medicare.

"It is predictable that the rollbacks will further discourage physicians from accepting assignment" and "result in an even further decrease in the assignment rate with the consequence that beneficiaries will pay an even larger proportion of their medical bills out-of-pocket," said the report.

To illustrate how the rollback operates, the report said a beneficiary or a physician who was paid $20 for an office visit in fiscal year 1975 may get only $18 in the current fiscal year 1976.

Hematology, Oncology Courses Held at UMC



Two-day intensive refresher courses in hematology and in oncology drew family physicians from instate as well as from Alabama and Louisiana to the University of Mississippi Medical Center. Hematology course participants included Dr. P. Temple Carney of York, Ala., seated, Dr. Robert T. Cates, left, and Dr. William Truly. Both Jacksonians, Dr. Cates and Dr. Truly also took the oncology study. The UMC Division of Continuing Health Professional Education sponsored the sessions with MRMP support.

SUBJECT INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "BR," Book Review; "CPC," Clinicopathological Conference; "MLB," Medico-Legal Briefs; "AP," Auxiliary Page; the asterisk (*) indicates an original article in the JOURNAL, and the author's name follows the entry in brackets. "Deaths," "Personals," and "New Members" are indexed under the letters "D," "P," and "M" respectively.

Matter pertaining to MSMA is indexed under "Mississippi State Medical Association." For the author index see page 400.

A

Abdomen
applications of ultrasound B scanning in the abdomen [Carter] 178-RS
Abortion
husband may not prevent wife from having abortion, 14-MLB
Adolescence
Rankin General Hospital opens adolescent psychiatric unit, 24-N
Aflatoxin
studied at UMC, 389-N
Alcoholics Anonymous
a salute to alcoholics anonymous [Martin] 295-E
Allergy
Southwest Allergy Forum scheduled, 136-N
Alpha Omega Alpha
Med Center hosts AOA visiting professor, 389-N
American Academy of Family Physicians
AAFP 1975 assembly set for Chicago, 310-N
American Academy of Orthopedic Surgery
Dr. Paul Derian is tapped by SICOT, 358-N
American Academy of Pediatrics
Dr. Blair Batson named to office, 24-N
receives Head Start consultation grant, 106-N
American College of Chest Physicians
calls for abstracts, 131-N
cardiology course set for Vermont, 58A-N
course in critical care scheduled, 189-N
American College of Ob-Gyn
Dr. Richard Boronow gets national recognition, 224-N
American College of Physicians
endocrine, metabolic and genetics studied, 311-N
Florida internists meet Oct. 31-Nov. 2, 304-N
internists meet in Virginia, 20A-N
internists will meet in Nashville, 309-N
preventive medicine studied at Memphis, 313-N
Texas internists meet Dec. 4-6, 360-N
American College of Sports Medicine
plans meeting, 52-N
American College of Surgeons
medical center hosts tumor registry course, 364-N
American Group Practice Association
Street Clinic receives AGPA accreditation, 58D-N
American Medical Association
AMA annual convention [Atkinson] 276-PP
AMPAC exceeds all-time high, 388-N
Dr. Hoyt Gardner addresses UMC Center assembly, 387-N
sponsors conference on the disabled physician, 81-L
urges caution in prescribing drugs, 20-N
American Psychosomatic Society
plans meeting, 90-N
Anesthesiology
clinical anesthesia course scheduled, 230-N
Mississippi society presents service award to Dr. Curtis Caine, 311-N
Antibiotics
intramuscular injections of antibiotics for salmonella [Blakey] 281-L
Aorta
indications and technique of aorto-coronary bypass [McMullan and Kilgore] *201
intra-aortic balloon counterpulsation [Kilgore and McMullan] *285
Arteriosclerosis
indications and technique of aorto-coronary bypass [McMullan and Kilgore] *201
results of surgery for coronary artery disease [Kilgore et al) *205
the recognition and medical management of lipid abnormalities [Galyean] *167
Arthritis
May 4 will be arthritis day during 107th MSMA annual session, 125-N
Aspirin
UMC participates in national study, 123-N
Athletics
coast athletic injury seminar held, 313-N
Auxiliary to MSMA
auxiliary page, 362
Dr. David speaks to, 88-N
Mrs. Opal Dees is SMA auxiliary president-elect, 87-N
MSMA auxiliary supports UMC children's hospital, 388-N
52nd annual session program, 105

B

Barnett, William O.
UMC professors of the year named, 222-N
Batson, Blair E.
named to AAP office, 24-N
Blue Cross-Blue Shield
ad in JOURNAL MSMA objected to [Edwards] 280-L
Blues are criticized in government study, 332-N
Dr. S. H. McDonnieal named vice chairman, 224-N
Books Reviewed
Acupuncture Anesthesia [Sams] 299-BR
Benson, Ralph C.: Handbook of Obstetrics and Gynecology [Godfrey] 85-BR
Bonnie, R. J. and Sonnenreich, M. R.: Legal Aspects of Drug Dependence [Russell] 355-BR
Campbell, Leslie Caine: Two Hundred Years of Pharmacy in Mississippi [Rogers] 85-BR
Cardoret, Remi J., and King, Lucy J.: Psychiatry in Primary Care [Champion] 121-BR
Chen, James Y. P.: Acupuncture Anesthesia in the Peoples' Republic of China [Sams] 299-BR
Dunphy, J. Englebert and Way, Lawrence W.: Current Surgical Diagnosis and Treatment. Second Edition [Hilbun] 279-BR
Ganong, William F.: Review of Medical Physiology. Seventh Edition [Langord] 333-BR
Jenkins, A. L.: Emergency Department Organization and Management [Leist] 381-BR
Kao, Frederick F.: Respiratory Research in the Peoples' Republic of China [Norman] 355-BR
Moritz, Alan R. and Morris, R. Crawford: Handbook of Legal Medicine. Fourth Edition [Derian] 187-BR
Quinn, Joseph R.: China Medicine as We Saw It [Brooks] 121-BR
Silver, Henry K.; Kempe, C. Henry; and Bruyn, Henry B.: Handbook of Pediatrics. Eleventh Edition [Sisson] 279-BR
Vaughan, Daniel; Asbury, Taylor; and Cook, Robert: General Ophthalmology. Sixth Edition [Blount] 47-BR
Walter, J. B. and Israel, M. S.: General Pathology. Fourth Edition [Puckett] 21-BR
Willson, J. R.; Beecham, C. T.; and Carrington, E. R.: Obstetrics and Gynecology. Fifth Edition [Holman] 333-BR
The Five Year Research and Development Agendum for Ultrasound Imaging Diagnostic Instrumentation [Carter] 381-BR
Boronow, Richard C.
gets national recognition, 224-N
Bower, John D.
named Mississippi's Physician of the Year, 161-N
Breast
mammography [Gibson] *74-RS
mammography [Harris] *149-RS
the early diagnosis of breast cancer [Martin] 153-E
UMC gets "after surgery" machine, 227-N
Brinson, Cleta
retires from the State Board of Health, 26-N

C

Caine, Curtis W.
receives service award from Miss. Society of Anesthesiologists, 311-N
Cancer See **Carcinoma.**
cancer control conference set, 130-N
mammography [Gibson] *74-RS
mammography [Harris] *149-RS
the early diagnosis of breast cancer [Martin] 153-E
Carbon Monoxide
half of Americans have high carbon monoxide levels, 20A-N
Carcinoma
cancer control conference set, 130-N
carcinoma of the penis [Elliott et al] *321
paraneoplastic manifestations in gastric carcinoma [Long et al] *337
the curability of metastatic choriocarcinoma [Odom and Boronow] *61
the early diagnosis of breast cancer [Martin] 153-E
Cardiology
course set for Vermont, 58A-N
tri-state cardiology meet scheduled, 160-N
Cardiovascular Disease
cardiovascular disease conference slated for Bethesda, Md., 312-N
postgraduate course set for Bal Harbour, 20A-N
radiological aspects of mitral valve disease [Gibson] *373-RS
sick sinus syndrome [Bennett] *172
the recognition and medical management of lipid abnormalities [Galyean) *167
Cardiovascular Surgery
indications and technique of aortocoronary bypass [McMullan and Kilgore] *201
intra-aortic balloon counterpulsation [Kilgore and McMullan] *285
results of surgery for coronary artery disease [Kilgore et al] *205
surgically correctable complications of myocardial infarction [McMullan and Kilgore] *288
Chemodectomas
a brief radiological review [Sauls] *346-RS
Choriocarcinoma
the curability of metastatic choriocarcinoma [Odom and Boronow) *61
Colon Disease
ischemic colitis [Long and Kees] *31
Comprehensive Health Planning, Division of
a new health package—for better or for worse [Dabney] 13-E
Gov. Bill Waller appoints two physicians to State Health Planning Advisory Council, 58-N
health planning removed from public decision, 58D-N
Continuing Medical Education
continuing medical education [Martin] 45-E
MDs get postgraduate education at UMC, 90-N
UMC receives gift for CME, 25-N
Coronary Disease
indications and technique of aortocoronary bypass [McMullan and Kilgore] *201
results of surgery for coronary artery disease [Kilgore et al] *205
surgically correctable complications of myocardial infarction [McMullan and Kilgore] *288
the recognition and medical management of lipid abnormalities [Galyean] *167
Culpepper, J. P., Jr.
dies in Hattiesburg, 310-N

D

Davis, J. T.
speaks to Woman's Auxiliary, 88-N
visits West Miss. Medical Society, 26-N
Deaths
Bennett, Hackett, 330
Berman, Maxwell David, 190
Biggs, William Otis, 118
Costley, Linfield, 190
Cox, James W., 190
Crocker, Ottis B., 306
Culpepper, J. P., Jr., 310
DeLaureal, Boni James, 54
Edmondson, Joseph S., 280
Felts, Nollie Carpenter, Sr., 54
Goodloe, William Henry, Jr., 54
Hackman, Pearl E., 158
Hollis, Daniel Lester, 190
Hunter, A. C., 54
Hutchins, James D., 280
Johnson, Lee White, 118
King, William A., 118
Laird, John Robert, 82
Lewis, Wiley D., 306
Nobles, William W., 306
Peeples, Robert H., 306
Rayburn, C. W., 382
Ricks, H. C., 281
Ross, T. Erskine, Jr., 280
Schmidt, Frank O., 158
Staton, Daniel E., 82
Suttle, W. M., 382
Wheaton, Robert E., 16
Dees, Mrs. Opal
is Southern Medical Association auxiliary president-elect, 87-N
Delta Medical Society
meets Oct. 8, 385-N
Derian, Paul S.
is tapped by SICOT, 358-N
Dermatology
dermatology course set for New York, 151-N
epidemic of scabies [Caccamise] 116-L
hair transplant symposium scheduled, 20-N
scabies: the itch [Blakey] 115-E
Diabetes
diabetic symposium held at UMC, 365-N
Draper, Edgar
will head UMC psychiatry department, 124-N
Drowning
near-drowning: a complex pathophysiologic injury [Long and Warren] *137
Drug Abuse
hallucinogenic mushrooms in Mississippi [Jacobs] *35
is the grass greener? [Blakey] 153-E
state drug treatment resources listed, 21-N
Drugs
AMA urges caution in prescribing drugs, 20-N
DEA registration numbers [Bland] 280-L
diiodohydroxyquin in the treatment of chronic nonspecific diarrhea in children [Blakey] 46-L
intramuscular injections of antibiotics for salmonella [Blakey] 281-L
UMC participates in aspirin study, 123-N

E

Ear
Miss. Speech and Hearing Association meeting set, 84D-N
Eastland, Senator James O.
praises family practitioners, 330-N
Education, Medical
congress considers medical school support, 157-N
Electrocardiography
studied at Medical Center, 388-N
Emergency Medical Care Unit (EMCU)
EMCU opens at Capitol, 46-N
Emergency Medicine
assembly slated, 136-N
Dr. W. B. Hopson appointed emergency director, 364-N
emergency care course scheduled, 29-N
studied in Atlanta, 130-N
Energy Crisis
no solutions appear to energy problem, 309-N
Eye
physicians are tested for glaucoma, 223-N
preschool program for visually impaired set, 127-N

F

Family Practice Specialist
family medicine opens model practice clinics, 188-N
MAFP elects officers and holds annual meeting, 283-N
MDs review family medicine at UMC, 284-N
medical center sets family practice review, 126-N
Sen. Eastland praises family practitioners, 330-N
primary care physicians take UMC course, 131-N
UMC course draws family physicians, 230-N
Foreign Medical Graduates (FMGs)
restrictions on FMGs urged, 365-N

G

Galbraith, J. Garber
is Rush Foundation Hospital guest speaker, 57-N
Gardner, Hoyt D.
speaks at University Med. Center, 387-N
Gastroenterology
ischemic colitis [Long and Kees] *31
paraneoplastic manifestations in gastric carcinoma [Long et al] *337
recurrent gastric bezoar in a postgastrectomy patient [Henderson] *42-RS
Glaucoma
physicians are tested for glaucoma, 223-N

Gonorrhea
gonorrhea [Henderson] *38
Gynecology
local ob-gyn workshops offered by UMC faculty, 26-N
mammography [Gibson] *74-RS
mammography [Harris] *149-RS
the curability of metastatic choriocarcinoma [Odom and Boronow] *61

H

Hattiesburg Clinic
is being expanded, 30-N
Health Care Costs
health costs rise, 163-N
people management is key to cut hospital costs, 351-N
Health Care Delivery
a new health package—for better or for worse [Dabney] 13-E
comments: medical care status in Mississippi [Dryja and Lampton] *142
the crisis in health care delivery [Brooks] *67
the government and health programs [Dabney] 115-E
HEW, Department of
HEW creates nursing home mess [Mathews] 13-E
HEW requests health service areas, 77-N
Health Security Act (HSA)
MHIC seeks HSA approval in Miss., 363-N
Heart See **Heart Disease.**
indications and technique of aortocoronary bypass [McMullan and Kilgore] *201
tri-state cardiology meet scheduled, 160-N
Heart Disease
heart disease studied at UMC, 28-N
radiological aspects of mitral valve disease [Gibson] *373-RS
results of surgery for coronary artery disease [Kilgore et al] *205
sick sinus syndrome [Bennett] *172
the recognition and medical management of lipid abnormalities [Galyean] *167
Hill, S. V. D.
Dr. S. V. D. Hill: member First Mississippi State Board of Health [Price] *376
Hopson, W. Briggs, Jr.
appointed emergency services director, 364-N
Hospitals
medical audit seminar set for Biloxi, 87-N
people management is key to cut hospital costs, 351-N
Hypertension
hypertension month committee organized, 166-N
May is high blood pressure month [Gibson] 154-E
SBH announces statewide program, 298-N
SBH's hypertension control program [Blakey] 332-L
the page kidney: an unusual cause of hypertension [Hester] *323-RS
UM course held, 365-N
Hypospadias
hypospadias: a general review [Keeton and Fenter] *340

I

Immunology
UMC researchers study blocking factors, 165-N
Insurance, Professional Liability
malpractice insurance [Atkinson] 216-PP
malpractice legislation is top issue, 88-N
malpractice solutions [Atkinson] 328-PP
MSMA/Bar committee holds meeting, 334-N
St. Paul announces policy change, 77-N
the malpractice crisis and the insurance carrier, 47-MLB
Internal Medicine See **Cardiology, Immunology and Gastroenterology.**
acute renal failure [Brent and Bower] *1
ischemic colitis [Long and Kees] *31
Texas internists meet, 360-N
The Half and Half Fingernail: the most significant onychopathological indicator of chronic renal failure [Daniel et al] *367
International Academy of Pathology
meets in New Orleans, 30-N
Isom, Thomas D.
Dr. Thomas Dudley Isom: member first Mississippi State Board of Health [Price] *7

J

Jeff Davis County
needs more M.D.s, 389-N
Joint Commission on Accreditation of Hospitals
medical audit seminar set for Biloxi, 87-N
Robert Wood Johnson Foundation
funds primary care services, 27-N

K

Kennedy, Rowland B.
R. B. Kennedy Memorial Neurology Fund established, 222-N
we will remember you—RBK [Mathews) 217-E
Kidney
acute renal failure [Brent and Bower] *1
nephrology course held at Medical Center, 27-N
ninth annual renal seminar held at UMC, 230-N
spontaneous closure of a renal arteriovenous fistula [Trapp et al] *91-RS
The Half and Half Fingernail: the most significant onychopathological indicator of chronic renal failure [Daniel et al] *367
the page kidney: an unusual cause of hypertension [Hester] *323-RS

L

Lane, Dewey H., Jr.
will head Miss. Economic Council, 25-N
Legislation
facts support revision of Medicaid fees, 45
malpractice legislation is top issue, 88-N
the 1975 Miss. legislative session, 162-N
Letters to the Editor
AMA appreciates August president's page [Layton] 306-L
AMA sponsors conference on the disabled physician [Todd] 81-L
American Physicians Art Association seeks members [Laughlin] 81-L
availability of insect sting emergency kits [Frazier] 356-L
compiling report on allergic reactions to insect bites [Frazier] 156-L
DEA registration numbers [Bland] 280-L
diiodohydroxyquin in the treatment of chronic nonspecific diarrhea in children [Blakey] 46-L
epidemic of scabies [Caccamise] 116-L
intramuscular injections of antibiotics for salmonella [Blakey] 281-L
meningococcal meningitis chemoprophylaxis [Blakey] 384-L
objection to ad in JOURNAL MSMA Edwards] 280-L
SBH's hypertension control program [Blakey] 332-L
status of practitioners of plastic surgery [Smith] 357-L
Lipids
the recognition and medical management of lipid abnormalities [Galyean] *167
Liver
rose bengal liver scanning [Sanders and Flowers] *9-RS
Lott, Trent
MPAC supports him, 28-N
Lungs
lung research-education project established, 164-N
pediatric pulmonary conference held, 336-N
tri-state thoracic conference held, 128-N

M

Magnolia Speech School
expands services, 60-N
Malpractice See **Insurance, Professional Liability.**
malpractice insurance [Atkinson] 216-PP
malpractice legislation is top issue, 88-N
malpractice solutions [Atkinson] 328-PP
MSMA/Bar committee holds meeting, 334-N
MSMA House convenes in special session, 385-N
St. Paul announces policy change, 77-N
the malpractice crisis and the insurance carrier, 47-MLB
Mammography
mammography [Gibson] *74-RS
mammography [Harris] *149-RS
Marijuana
is the grass greener? [Blakey] 153-E
Maternal Mortality
maternal mortality in Miss.—1972 [Wiener] *371
McDonnieal, S. H.
named vice chairman of Blue Cross-Blue Shield of Miss., 224-N

Medicaid
facts support revision of Medicaid fees, 45
new UR regulations are postponed, 160-N
Medical Care, Quality of
comments: medical care status in Mississippi [Dryja and Lampton] *142
summary of the seven points of responsibility for quality medical care—the citizens' right, 295-MLB
Medical History
Dr. S. V. D. Hill: member First Mississippi State Board of Health [Price] *376
Dr. Thomas D. Isom: member first Mississippi State Board of Health [Price] *7
is the past relevant to the present or the future? [Gibson] 79-E
UMC History of Medicine Society meets, 26-N, 87-N, 158-N, 386-N
Medical Licensure
SBH sends out license renewal forms, 188-N
thoughts on recertification [Dabney] 277-E
Medical Practice
disincentives to practice [Mathews] 329-E
Medicare
disincentives to practice [Mathews] 329-E
fee carving opposed, 390-N
Medicare updates allowable charges, 298-N
new UR regulations are postponed, 160-N
not exhausting remedies bars suit against Medicare carrier, 352-MLB
report cites Medicare gaps, 58-N
Medico-Legal Briefs
husband may not prevent wife from having abortion, 14
the malpractice crisis and the insurance carrier, 47
involuntary commitment statutes held invalid for vagueness, 80
reference to doctor's insurance coverage warrants new trial, 117
professional corporation denied damages for physician's injuries, 155
no negligence in failure to diagnose appendicitis in child, 184
podiatrist entitled to hearing before denial of staff privileges, 217
landmark decision in mental health [Roberts] 277
restrictions in Missouri abortion statute upheld, 382
summary of the seven points of responsibility for quality medical care—the citizens' right, 295
physician not liable for failing to inform hospital of his absence, 329
not exhausting remedies bars suit against Medicare carrier, 352
Members, New
Abangan, Rolando T., 118
Aden, William M., 380
Akers, John R., 118
Akins, Charles D., 156
Bess, Lloyd George, 84
Blackwood, Donald James, 84
Blanton, Terrell D., 218
Bobo, William Owen, 84
Boone, Gary A., 118
Booth, William H., Jr., 218
Bordelon, Fred Calvin, 84
Box, Benjamin Edgar, 187
Boyd, Arthur M., 84
Briggs, Frank R., 120
Bryant, W. Michael, 84
Buchanan, Benjamin H., Jr., 156
Burroughs, Judy Faye, 84
Cabell, Thomas Hargrove, 84
Carter, Kenneth Gilbert, 52
Chandler, Rodney R., 297
Clay, John C., 120
Christian, Ronnie Scott, 52
Couey, Ira Lamar, 84
Dearman, Henry Burkett, 52
Delivorias, Laurin Ann, 187
Dement, Frank E., III, 52
Durst, Edward Frank, 84
Ehlert, William Rowe, 187
Fabian, Judith Ann, 120
Frothingham, Rodney E., 52
Gillis, Wilfred R., 120
Gonzalez, Sergio, 380
Greer, Thomas H., 120
Gregory, Ray N., 52
Harrell, Rebecca, 120
Hatten, Lewis E., 187
Hellems, Harper K., 120
Hofmann, Larry V., 52
Hunter, John Willis, Jr., 52
Lee, Robert C., 380
Lyle, Russell R., 120
Massey, Mitchell C., 156
McCraney, Ward Thomas, 84
McFatter, Charles Wayne, 52
McMullan, Martin H., 120
Meyer, Jon Rayner, 187
Monaghan, Brooks, Jr., 218
Morris, Glenn F., 380
Murfee, John A., Jr., 280
Nicholls, Richard A., 120
Overby, James Allen, 84
Owen, William Douglas, 297
Parker, John H., Jr., 84
Pineda, Mario R., 84
Randle, Thomas A., Jr., 52
Rausa, Alfio, 120
Reid, May Virginia, 120
Robertson, Gerald M., 280
Sanders, Harvey C., 380
Seyler, Clifford A., 120
Shaalan, Mahmoud, 218
Smith, Beverly Ann B., 84
Steiger, Ezra, 330
Valenzuela, Raul E., 84A
Wade, Stanley A., Jr., 120
Warren, Richard B., Jr., 84A
Weeks, Charles T., 218
Wesson, Thomas W., Jr., 16
Wilkerson, George E., 380
Meningitis
meningoccocal meningitis prophylaxis [Blakey] 384-L
Mental Health
ETV produces mental health series, 126-N
landmark decision in mental health [Roberts] 277-MLB
Mississippi Academy of Family Physicians
elects officers and holds annual meeting, 283-N
Mississippi Arts Festival
physicians' wives work with 1975 arts festival, 127-N
1976 arts festival announces plans, 358-N
Mississippi Authority for ETV
produces mental health series, 126-N
Mississippi Bar Association
MSMA/Bar committee holds meeting, 334-N
Mississippi Board of Nursing
stops LPNs from administering IVs, 336-N
Mississippi Clearinghouse for Drug Misuse Information
state drug treatment resources listed, 21-N
Mississippi Society, American Association of Medical Assistants
holds annual convention, 225-N
Mississippi Economic Council
Dr. Dewey Lane is president-elect, 25-N
Mississippi Foundation for Medical Care
an introduction to the development of screening criteria for the Miss. PSRO [Miller and Renick] *326
Dr. Tom Mitchell named Miss. PSRO director, 157-N
introducing: the director of the Miss. PSRO, 221-N
Miss. PSRO begins operation in three hospitals, 53-N
PSRO is discussed at UMC, 165-N
the criteria manual of the Miss. PSRO [Miller and Renick] *343
Mississippi Health Improvement Corporation
MHIC seeks HSA approval, 363-N
Mississippi Heart Association
hypertension month committee organized, 166-N
May is high blood pressure month [Gibson] 154-E
tri-state cardiology meet scheduled, 160-N
Mississippi Hospital Association
medical audit seminar set for Biloxi, 87-N
Mississippi Interagency Council on Smoking
meets in Sept., 364-N
Mississippi Lung Association
D.S.A. presented to Dr. Robert E. Schwartz, 226-N
lung research-education project established, 164-N
pediatric pulmonary conference held, 336-N
summer scholarships provided to medical students, 27-N
tri-state thoracic conference held, 128-N
Mississippi Medical Political Action Committee
AMPAC exceeds all-time high, 388-N
facts support revision of Medicaid fees, 45
MPAC has impact, 330-N
supports Trent Lott, 28-N
Mississippi Methodist Rehabilitation Center
Sunday, May 4, will be arthritis day during 107th MSMA annual session, 125-N
Mississippi Public Health Association
holds annual meeting in Jackson, 359-N
Mississippi Regional Medical Program
See **Postgraduate Calendar.**
comments: medical care status in Mississippi [Dryja and Lampton] *142
MHIC seeks HSA approval, 363-N
Miss. medical-dental workshop held, 363-N

Mississippi Society for the Prevention of Blindness
physicians are tested for glaucoma, 223-N
Mississippi Society of Anesthesiologists
presents service award to Dr. Curtis Caine, 311-N
Mississippi Speech and Hearing Association
meeting set, 84D
Mississippi State Board of Health
announces statewide hypertension program, 298-N
diiodohydroxyquin in treatment of chronic nonspecific diarrhea in children [Blakey] 46-L
Dr. W. B. Hopson appointed emergency director, 364-N
Dr. S. V. D. Hill: member first Mississippi State Board of Health [Price] *376
Dr. Thomas D. Isom: member first Mississippi State Board of Health [Price] *7
home health program provides care, 57-N
intramuscular injections of antibiotics for salmonella [Blakey] 281-L
issues PA policy, 77-N
meningococcol meningitis prophylaxis [Blakey] 384-L
Miss Cleta Brinson retires, 26-N
Miss. Public Health Association holds annual meeting in Jackson, 359-N
names TB study committee, 56-N
offers presentation on smoking and health, 60-N
SBH's hypertension control program [Blakey] 332-L
sends out license renewal forms, 188-N
smoking mothers and infant health [Blakey] 14-E
TB demonstration program implemented, 304-N
TB patients will be treated at McComb, 386-N
Mississippi State Medical Association
address of the president [Davis] 211
Board of Trustees—holds fall meeting, 23-N; names 1975-76 officers, 192-N; conducts annual summer meeting at Clarksdale, 335-N
Constitution and By-Laws, 268
Council on Legislation—facts support revision of Medicaid fees, 45-N; the 1975 legislative session, 162-N
Council on Medical Education—continuing medical education [Martin] 45-E
Council on Scientific Assembly—announces format for 108th annual session, 305-N; begins work for '76, 192-N
Emergency Medical Care Unit—opens at Capitol, 46-N
Davis, J. T.—speaks to Woman's Auxiliary, 88-N; visits West Miss. Medical Society, 26-N
Dees, Mrs. Opal—is SMA auxiliary president-elect, 87-N
Delta Medical Society—meets Oct. 8, 385-N
helps sponsor medical audit seminar set for Biloxi, 87-N
House of Delegates—handbook of 107th Annual Session, 107; text of proceedings, 231-267; convenes in special session, 385-N; "It's Time" [Dabney] 379-E
JOURNAL MSMA—Blue Cross ad in June issue objected to [Edwards] 280-L
Kennedy, Rowland B.—R. B. Kennedy Memorial Neurology Fund established, 222-N; we will remember you —R.B.K. [Mathews] 217-E
malpractice insurance—St. Paul announces policy change, 77-N
Mississippi Foundation for Medical Care—Dr. Tom Mitchell named Miss. PSRO director, 157-N; introducing: the director of the Miss. PSRO, 221-N; the criteria manual of the Miss. PSRO [Miller and Renick] *343; the Miss. PSRO program begins operation in three hospitals, 53-N
Mississippi Medical Political Action Committee—AMPAC exceeds all-time high, 388-N; MPAC has impact, 330-N; MPAC supports Trent Lott, 28-N
MSMA/Bar Committee—holds meeting, 334-N
MSMA-Robins Award is announced, 387-N
President's Page, Davis—"We Need You," 12-PP; "Human Satisfaction," 44-PP; "Continuing Medical Education," 78-PP; "Confidentiality," 114-PP; "All Roads Lead to 'Rome,'" 152-PP
President's Page, Atkinson—"The 107th Annual Session," 182-PP; "Malpractice Insurance," 216-PP; "AMA Annual Convention," 276-PP; "What Can I Give?" 294-PP; "Malpractice Solutions," 328-PP; "The Pressures of Change," 350-PP; "Vigilance Is the Price of Liberty," 378-PP
presents check to SAMA president, 126-N
Professional Standards Review Organization in Mississippi—Dr. Tom Mitchell named Miss. PSRO director, 157-N; introducing: the director of the Miss. PSRO, 221-N; the criteria manual of the Miss. PSRO [Miller and Renick] *343; the Miss. PSRO program begins operation in three hospitals, 53-N
107th Annual Session—Dr. Jack Atkinson is inaugurated president, Dr. Lyne S. Gamble is named president-elect, 193-N; House of Delegates handbook, 107; official call and program, 94; proceedings of the House of Delegates, 231; specialty societies hold concurrent meetings, 199-N; Sunday, May 4, will be arthritis day during 107th Annual Session, 125-N; will offer something for everyone, 89-N
108th Annual Session—Council on Scientific Assembly begins work for '76, 192-N; announces format for 108th Annual Session, 305-N
West Miss. Medical Society—Dr. J. T. Davis visits society, 26-N
Woman's Auxiliary—Dr. J. T. Davis addresses WA/MSMA meeting, 88-N; Mrs. Opal Dees is SMA auxiliary president-elect, 87-N; WA/MSMA page, 362; WA/MSMA—52nd annual session program, 105; supports UMC children's hospital, 388-N
Mississippi Thoracic Society See **Mississippi Lung Association.**
pediatric pulmonary conference held, 336-N
Mitchell, Tom H.
introducing: the director of the Miss. PSRO, 221-N
named Miss. PSRO director, 157-N
Mushrooms
hallucinogenic mushrooms in Miss. [Jacobs] *35
Myocardial Infarction
surgically correctable complications of myocardial infarction [McMullan and Kilgore] *228

N

National Heart and Lung Institute
recruits patients for study, 189-N
Neoplasms See **Carcinoma.**
paraneoplastic manifestations in gastric carcinoma [Long et al] *337
Newborn Care
Meridian will host maternal-infant meets, 165-N
Miss. hosts newborn course, 228-N
newborn, ventilator technique courses set at UMC, 60-N
physicians study newborns at UMC, 163-N
smoking mothers and infant health [Blakey] 14-E
ventilator techniques studied at UMC, 284-N
Nuclear Power
the development of nuclear power [Brooks] 183-E
Nursing
Board of Nursing stops IVs, 336-N
nurse practitioner training offered, 226-N
nursing survey reveals role of touch, 20D-N
Nursing Homes
HEW creates nursing home mess [Mathews] 13-E

O

Obstetrics
local ob-gyn workshops offered by UMC faculty, 26-N
maternal mortality in Miss.—1972 [Weiner]* 371
Meridian will host maternal-infant meets, 165-N
smoking mothers and infant health [Blakey] 14-E
Ophthalmology
course set for Lexington, 77-N
preschool program for visually impaired set, 127-N
Orthopedic Surgery
bones and joints disease course set, 20D-N
Sunday, May 4, will be arthritis day during 107th annual session, 125-N
Otolaryngology
medical center holds ENT course, 129-N
physicians take ENT course, 130-N

P

Pediatrics
Dr. Nigam appointed to UMC pediatrics staff, 228-N
first five-state pediatric pulmonary conference held, 282-N

hypospadias: a general review [Keeton and Fenter] *340
Miss. hosts newborn course, 228-N
pediatric chest radiology course set, 25-N
pediatric pulmonary conference held, 336-N
physicians study newborns at UMC, 163-N
postgraduate course set for Bal Harbour, 20A-N
postgraduate pediatrics course held, 282-N
smoking mothers and infant health [Blakey] 14-E
ventilator techniques studied at UMC, 284-N
Penis
carcinoma of the penis [Elliott et al] *321
hypospadias: a general review [Keeton and Fenter] *340
Personals
Abraham, Ralph E., 122
Abraham, Robert, 186
Adams, A. M., Jr., 86
Aden, William M., 15
Ainsworth, Temple, 382
Alvis, Joel, 382
Anderson, Thomas J., 122, 218
Andy, O. J., 186, 352
Apple, Ernest F., 352
Arens, James F., 15, 49, 186, 278, 382
Arrington, George L., 333
Atkinson, Bruce E., 278
Atkinson, Jack A., 218, 278
Austin, J. W., 86
Austin, William K., Jr., 86, 299
Bailey, S. Lamar, 333
Bailey, T. O., 299
Baine, Rodney W., 299
Ball, Leonard D., 299
Ball, Ottis G., 218
Ballard, Robert C., 352
Barham, Ed Dalton, 352
Barkley, Jare L., 15, 156, 382
Barlow, James B., 352
Barnes, Helen, 382
Barnes, Thomas, 15, 186
Barnett, Jim C., 86, 156
Barnett, William O., 50, 218
Bass, Charles P., 15
Batson, Blair, 50
Baxter, Malcolm D., Jr., 299
Bazzone, Victor T., 218
Beacham, A. V., 50
Bell, Ralph, 86
Bennett, Hackett, 86
Biggs, Jack, 15
Bishop, Hal D., 122
Blount, Richard L., 299
Bobo, Edgar E., 15
Bolton, Dewitt L., 86, 156
Boggan, Willard H., 353
Bond, Pat, 353
Booth, Donald J., 86, 156
Boronow, Richard C., 50, 278, 352, 383
Borrell, Luis, 333
Bouchillon, C. D., 156
Bourland, Walter, 352, 353
Bowen, Frank W., 156
Bower, John D., 122
Bowlin, John W., 334
Box, Benjamin E., 186
Bradley, William G., 15
Bramlett, Eugene V., 86
Brandon, L. H., Jr., 86
Brann, Alfred W., Jr., 122
Brasfield, Dan L., 352
Brent, Alvin E., Jr., 50
Brock, H. D., 156
Brown, R. M., 15
Buchanan, Ben H., 334
Buckley, Robert L., Jr., 352
Burman, R. G., 156, 186
Burris, Richard Gerald, 300
Butani, Kanta P., 186
Byarly, John W., 86
Caine, Curtis W., 122
Calvert, William E., 334
Campbell, Guy D., 16, 186, 219, 383
Casey, Michael R., 156
Cater, Robert J., 333
Chavez, Carlos M., 50, 122, 352, 383
Chidester, Linda, 122
Clay, T. F., 50
Clippinger, D. L., 156
Cockrell, M. E., Jr., 353
Conerly, Wallace, 16
Copeland, John T., 122
Crane, Edmund H., Jr., 299
Crick, Gene, 122
Criss, Ralph, 87
Cronin, Irwin H., 156
Crosthwait, James, 383
Currie, Edward H., 334
Dabbs, Rome Grafton, 50
Dale, Warren B., 334
Day, Larry, 353
Dear, H. Davis, 300
Dement, Roy, 299
Diaz, Albert L. M., 353
Dickerson, Quinton, 383
Dilworth, Robert E., 334
Donald, Robert L., 156
East, Isaac C., 86
Eckford, John F., 15
Ederington, John B., 15, 123
Edwards, C. Mims, 353
Edwards, J. B., 156
Ellis, Marshall Stone, 334
Evans, John, 15, 353
Fannin, W. Raymond, Jr., 86
Ferguson, J. V., Jr., 122
Fernando, I. C., 300
Fineburg, Steven B., 300
Flagg, G. B., 278
Foose, Michael, 334
Forman, Robert L., 186
Freeman, Erwyn E., 218
Frothingham, Rodney, 50
Fulcher, L. H., 87
Fyke, F. E., Jr., 50
Gabbert, Elmo P., 186
Gabel, Joseph C., 16, 123
Ganaraj, P. S., 300
Gandy, Thomas, 86
Garner, Mable T., 383
Gassaway, John, 86
Gates, Richard F., 186
Gates, W. C., 86
Gibson, John Y., 186, 334
Gillespie, William J., 334
Godfrey, W. D., 87, 383
Goff, Barbara, 122
Gordon, Gary G., 300
Goudelock, J. C., 278
Graham, Robert M., 334
Graves, Glen, 300
Graves, J. A., 122
Graves, Sidney O., 86, 278
Gruich, Frank, 15
Hamilton, George C., Jr., 334
Hammack, Thomas, 383
Hardy, James D., 86, 123, 186, 219, 353
Harrington, John N., 334
Hartness, Stanley, 333
Harvey, Marvin, 15
Hatten, Karl W., 15
Hawkins, Mary, 123
Heidisch, Rita, 186
Heitzman, H. Brad, 334
Hellman, Michael, 300
Henry, D. Chan, 300
Hey, John, 122
Hickman, B. T., 278, 353
Hilbun, Glyn R., 186
Hinman, M. E., 15, 300
Hodges, Lucien R., 87, 219
Holbert, Robert Douglas, 15
Holden, Thomas E., 87
Hollis, Richard, 383
Holloway, James P., 353
Holmes, J. W., 86
Holmes, Verner S., 299
Holmes, Wendell, 186
Hopkins, Donald A., 300
Howard, Anse B., III, 156
Hudson, Harold K., 219, 300
Hudson, J. M., 50
Hughes, Wayne A., 278
Hull, C. G., III, 300
Iacullo, Robert L., 383
Irby, Henry E., 123
Isbell, Jimmy E., 300
Izard, Steve, 15
Jabaley, Michael E., 123, 353
Jackson, John F., 219
Janes, Julian, 15
Janet, Hansel, 300
Jeter, Marvin, 49
Johnson, Ben B., 50
Johnson, Samuel B., 278
Jones, Arthur, 383
Jones, Edley H., 50, 123
Jordon, C. M., 87
Kahlstorf, William, 300
Keady, Dwight S., 353
Keeton, James, 353
Kelly, Roy, 383
Kepner, Sewell P., 219
Keyes, Prentiss F., 156
Kimble, Ray, 300
Kinsey, Herbert P., 334
Kuiper, Hendrik K., 278
Kurdy, Yousef, 15
Laird, Earl, Sr., 334
Lamar, Wayne T., 219
Lamb, Jones W., 383
Lampton, T. D., 156
Lane, Dewey, 156
Langford, Herbert G., 123, 353
Langston, Ledon, 123, 186
Laws, Albert L., 278
Lee, John P., 300
Lewis, Nathan B., 219
Lipscomb, Larry, 353
Lipscomb, Lewis D., 87
Little, R. A., 156
Lloyd, Judson F., 156
Lockey, Myron W., 15, 86, 383
Lorentz, R. J., 15
Louis, Tom III, 383
Love, Robert, 50
Love, S. Kimble, 278
Lovelace, John R., 86
Lowery, Roger L., 300
Lyerly, Donald Newton, 219
Lyle, Russell R., 156
Maniktahla, Kanwal N., 278
Mann, John E., Jr., 156

Manning, James O., 86
Marlin, Roger B., 300
Massey, F. Mitchell, 334
Masterson, Chester W., 123
Mayers, William M., 122
Mayers, W. W., 383
McCarty, Eugene, 86
McIlwaine, James S., Jr., 156
McIntire, L. L., 219
McKell, William M., 15
McLain, Patrick G., 300
McMillan, M. S., 87
McMillin, F. Lamar, Jr., 300
McQueen, James N., 186, 334
McQuinn, William C., 334
Merrell, Wafford, 382
Meyer, William H., 86, 300
Miles, Charles D., 334
Miller, Richard C., 186, 219, 383
Mills, Henry P., Jr., 219
Mitchell, Don O., 383
Mitchell, Robert, 86
Mitchell, Tom H., 15, 219
Moffitt, Ellis M., 86, 87
Moore, Paul H., 156, 383
Morris, Glenn F., 86, 353
Morrison, Francis S., 16, 123, 157, 186, 278, 353
Motley, Ray F., 86
Mounger, S. G., 122
Neely, William A., 50
Neill, Charles L., 219
Neill, Emmett, 383
Neill, Walter R., 219
Nelson, Gary A., 16
Nelson, Howard, 86
Nettles, Dexter C., 16
Nichols, Frank A., 334
Nix, J. Elmer, 157
Norman, Joe R., 186, 219, 383
North, Edward R., Jr., 16, 123, 334
O'Brien, Edward, 278
Oliphant, W. W., 334
Ong, Michael, 383
Owen, David, 353
Owen, William, 16
Owens, Louis Jennings, 156
Parker, John, 123
Pate, S. Ray, 300, 334
Patino-Gamboa, Orlando A., 353
Patrick, Bernard S., 86, 157
Patterson, John M., 86, 157
Patterson, W. J., 86
Pearson, John, 186
Peeler, Joe G., Sr., 186
Peters, Anice Fay, 50
Pettis, J. L., 50
Pharr, Max L., 86, 87
Pierce, Paul W., III, 334
Pineda, Mario R., 50, 186
Powell, John E., 156
Pressler, James W., 86, 123
Price, E. J., Jr., 186
Pullen, Jeanette, 383
Purdy, James John, 300
Purvis, Thomas, 383
Raines, O. C., III, 156
Randle, Thomas A., 50, 86
Rawson, John E., 383
Rayner, Donald, 219
Reed, Kenneth, 383
Rennick, Ronald L., 50, 186
Rhoden, Richard E., 334
Richardson, Glenn B., 278, 353
Roberts, Curtis D., 157
Robinson, G. Robert, 300
Robinson, William Thomas, 86
Rogers, Lee H., 86
Rose, Walter, 353
Rosenblatt, W. H., 383
Rouse, Douglas W., 157
Rubenstein, Louis A., 156
Rubio, Antonio M., 50
Russell, James R., 219
Sams, James H., 123, 353
Sams, William C., 278
Santangelo, A. J., 87
Sartin, Jack, 299
Scanlon, Leo J., 219
Schmidt, Robert J., 353
Shaw, G. Boyd, 16, 86, 219, 353
Shaw, Thomas R., 334
Shell, John R., 186
Sherline, Donald M., 353, 383
Simmons, Omar, 87
Singley, Thomas R., 157
Sison, Fraciano P., Jr., 300
Sistrunk, W. F., 87
Sloan, Robert, 49
Smith, Bennett E., Jr., 353
Smith, Beverly Ann, 87
Smith, George V., 353
Smith, J. George, 353, 383
Smith, Jimmie L., 334
Smith, McKamy, 300
Smith, Perrin N., 334
Smith, Robert R., 157, 219
Spears, D. E., 87
Spell, James P., 157, 218, 353
Spencer, G. O., Jr., 86
Spraberry, A. P., 15
Sproles, Arthur, 382
Stevens, Thomas E., 87
Stowers, K. B., 50
Strange, Dempsey, 383
Stringer, W. F., 50
Stubblefield, G. Crawley, Jr., 16, 300
Suess, James, 383
Taylor, Roma, 123
Temple, Van H., 300
Tharp, Charles P., 300
Thigpen, J. Tate, 278
Thomas, David R., 300
Thompson, R. H., 87
Thompson, R. L., 334
Tipton, Ancel C., Jr., 278
Tolbert, Virginia S., 123
Trahan, Ouida Jo, 50
Trosclair, B. G., 50
Trunzler, Basil, 383
Tubb, Grayden, 156
Tyson, Robert E., 87
Ulmer, David, 123
Valenzuela, Raul E., 383
Walker, Joe W., 87, 123
Wansley, Bill, 123
Warner, William C., 383
Warren, Gene, 334
Warren, Glen C., 219
Watkins, Horace, III, 383
Webb, Eugene, 122
Weems, W. Lamar, 49, 87, 353
Welch, Carl, 353
Welch, Paul B., 218
Weldy, Joe, 186
Wessler, Gerald, 123
Wheatley, Mary B., 186
Whitaker, Thurston, 383
White, John J., 50, 278
Whites, Dayton E., 334
Whitwell, Earl E., 334
Wiener, Julian, 383
Wilburn, Frank W., 300
Wilkerson, George E., 186
Wilkins, Louie F., 300
Williams, C. T., Jr., 122
Williams, John R., 16
Williams, Morris E., 300
Wilson, Thomas E., III, 219, 278
Winkler, M. M., Jr., 300
Wood, Eugene G., Jr., 156
Wood, William L., 157
Woodbridge, H. B., 87
Yates, A. J., 156
Zielinski, John J., 156

Pharmacy
DEA registration numbers [Bland] 280-L
state pharmacists have new publication, 131-N

Physicians
DEA registration numbers [Bland] 280-L
disincentives to practice [Mathews] 329-E

Physicians Assistants
SBH issues PA policy, 77-N

Postgraduate Calendar
featured on pages 18, 50, 84A, 116, 166, 187, 280, 302, 336, 354, 380

Pregnancy See **Obstetrics.**

Professional Liability Insurance
malpractice solutions [Atkinson] 328-PP
MSMA/Bar committee holds meeting, 334-N
MSMA House convenes in special session, -N
St. Paul announces policy change, 77-N
the malpractice crisis and the insurance carrier, 47-MLB

Professional Standards Review Organizations
an introduction to the development of screening criteria for the Miss. PSRO [Miller and Renick] *326
confidentiality [Davis] 114-PP
discussed at UMC, 165-N
Dr. Tom Mitchell named Miss. PSRO director, 157-N
introducing: the director of the Miss. PSRO, 221-N
the criteria manual of the Miss. PSRO [Miller and Renick] *343
the government and health programs [Dabney] 115-E
the Miss. PSRO program begins operation in three hospitals, 53-N

Psychiatry
Dr. Draper will head UMC department, 124-N
grants go to schools, 22-N
Rankin General Hospital opens adolescent unit, 24-N

Public Health See **Mississippi State Board of Health** and **Mississippi Public Health Association.**

Pulmonary Disease
changes in handling pulmonary tuberculosis [Reid] *315
first five-state pediatric pulmonary conference held, 282-N
newborn ventilator techniques courses set at UMC, 60-N
pediatric chest radiology course set, 25-N
pediatric pulmonary conference held, 336-N

R

Radiologic Seminars
CXXXXVII: rose bengal liver scanning [Sanders and Flowers] *9-RS

CXXXXVIII: recurrent gastric bezoar in a postgastrectomy patient [Henderson] *42-RS
CXXXXIX: mammography [Gibson] *74-RS
CL: spontaneous closure of a renal arteriovenous fisulta [Trapp et al] *91-RS
CLI: mammography [Harris] *149-RS
CLII: applications of ultrasound B scanning in the abdomen [Carter] *178-RS
CLIII: the lateral decubitus radiograph: an aid to the diagnosis of endobronchial foreign bodies [Blumenthal] *209-RS
CLIV: the expanding role of diagnostic radiology [Gibson] *291-RS
CLV: the page kidney: an unusual cause of hypertension [Hester] *323-RS
CLVI: chemodectomas: a brief radiological review [Sauls] *346-RS
CLVII: radiological aspects of mitral valve disease [Gibson] *373
Radiology See **Radiologic Seminars.**
Aspen radiology conference scheduled, 29-N
genitourinary radiology course set, 151-N
pediatric chest radiology course set, 25-N
UMC now has an EMI scanner, 363-N
Rankin General Hospital
opens adolescent psychiatric unit, 24-N
Recertification
thoughts on recertification [Dabney] 277-E
Regional Medical Programs
a new health package—for better or for worse [Dabney] 13-E
health planning removed from public decision, 58D-N
MHIC seeks HSA approval in Miss., 363-N
Miss. medical-dental workshop held, 363-N
Renal Failure
acute renal failure [Brent and Bower] *1
The Half and Half Fingernail: The most significant onychopathological indicator of chronic renal failure [Daniel et al] *367
Ricks, H. C.
dies in Jackson, 281-N
A. H. Robins Co.
MSMA Robins Award announced, 387-N
Rush Foundation Hospital
Dr. J. G. Galbraith is guest speaker, 57-N

S

Safety
hunters' safety (Lockey) 351-E
Salmonella Infections
intramuscular injections of antibiotics [Blakey] 281-L
Scabies
epidemic of scabies [Caccamise] 116-L
scabies: the itch [Blakey] 115-E
Schwartz, Robert E.
presented MLA distinguished service award, 226-N
Sexuality
marital and sexual dysfunction studied, 58D-N
Sick Sinus Syndrome
sick sinus syndrome [Bennett] *172
Smoking
Miss. Interagency Council on Smoking meets, 364-N
SBH offers presentation on smoking and health, 60-N
smoking mothers and infant health [Blakey] 14-E
Southern Medical Association
Mrs. Opal Dees is auxiliary president-elect, 87-N
Stomach See **Gastroenterology.**
paraneoplastic manifestations in gastric carcinoma [Long et al] *337
recurrent gastric bezoar in a postgastrectomy patient [Henderson] *42-RS
Street Clinic
receives AGPA accreditation, 58D-N
St. Dominic-Jackson Memorial Hospital
two physicians appointed to board, 88-N
St. Paul Fire and Marine Company
announces policy change, 77-N
Student American Medical Association
MSMA presents check to SAMA president, 126-N
Surgery
Dr. Zollinger headlines UMC surgical forum, 22-N
hypospadias: a general review [Keeton and Fenter] *340
indications and technique of aorto-coronary bypass [McMullan and Kilgore] *201
intra-aortic balloon counterpulsation [Kilgore and McMullan] *285
recurrent gastric bezoar in a postgastrectomy patient [Henderson] *42-RS
results of surgery for coronary artery disease [Kilgore et al] *205
second annual UMC surgical forum held, 164-N
surgically correctable complications of myocardial infarction [McMullan and Kilgore] *288
UMC surgical forum is this month, 90-N

T

Thyroid
UMC researchers study thyroid hormones, 225-N
Tuberculosis
changes in handling pulmonary tuberculosis [Reid] *315
SBH names TB study committee, 56-N
TB demonstration program implemented, 304-N
TB patients will be treated at McComb, 386-N
Tumors
carcinoma of the penis [Elliott et al] *321
chemodectomas: a brief radiological review [Sauls] *346-RS
medical center hosts tumor registry course, 364-N
paraneoplastic manifestations in gastric carcinoma [Long et al] *337
the curability of metastatic choriocarcinoma [Odom and Boronow] *61
the early diagnosis of breast cancer [Martin] 153-E

U

Ultrasound
applications of ultrasound B scanning in the abdomen [Carter] *178-RS
University of Mississippi
hypertension course held, 365-N
VD awareness program held in Oxford, 163-N
University of Mississippi Medical Center
adds to faculty, 56-N
Aflatoxin studied at UMC, 389-N
Canadian physician visits medical center, 56-N
continuing education receives gift, 25-N
diabetic symposium held at UMC, 365-N
Dr. Blair Batson named to AAP office, 24-N
Dr. Richard Boronow gets national recognition, 224-N
Dr. Edgar Draper will head psychiatry department, 124-N
Dr. Hoyt Gardner speaks at University Med Center, 387-N
Dr. A. Markov joins med center faculty, 220-N
Dr. S. K. Nigam appointed to pediatrics staff, 228-N
Dr. Paul Derian is tapped by SICOT, 358-N
Dr. Robert Zollinger headlines surgical forum, 22-N
EKGs studied at Medical Center, 388-N
family doctors study hematology, oncology, 312-N
family medicine opens model practice clinics, 188-N
family physicians take course, 131-N
features visiting professors, 136-N
Goldberger lecturer featured, 130-N
has new faculty members, 128-N
heart disease studied at UMC, 28-N
hematology, oncology courses held, 390-N
History of Medicine Society meets, 26-N, 87-N, 158-N, 386-N
holds ENT course, 129-N
local ob-gyn workshops offered by UMC faculty, 26-N
marks 20th anniversary, 360-N
MDs get postgraduate education, 90-N
MDs review family medicine, 284-N
Med Center hosts AOA visiting professor, 389-N
medical center adds clinical services wing, 228-N
medical center adds new faculty, 227-N
medical center announces new faculty, 308-N
medical center hosts tumor registry course, 364-N
Meridian will host maternal-infant meets, 165-N
Mississippi hosts newborn course, 228-N
Miss. medical-dental workshop held, 363-N
MSMA auxiliary supports UMC children's hospital, 388-N
MSMA presents check to SAMA president, 126-N
nephrology course held at medical center, 27-N
nephrology is studied at medical center, 312-N
newborn, ventilator technique courses set, 60-N

ninth annual renal seminar held, 230-N
nurse practitioner training offered, 226-N
participates in aspirin study, 123-N
physicians, clergy meet at UMC, 388-N
physicians study newborns, 163-N
physicians take ENT course, 130-N
postgraduate prediatrics course held, 282-N
PSRO is discussed, 165-N
researchers study blocking factors, 165-N
School of Medicine enrolls over 500, 332-N
second annual UMC surgical forum held, 164-N
sets family practice review, 126-N
state physicians attend UMC seminar, 364-N
state physicians take intensive courses, 24-N
summer scholarships provided by MLA, 27-N
surgical forum is this month, 90-N
UMC announces new faculty and promotions, 284-N
UMC course draws family physicians, 230-N
UMC gets "after surgery" machine, 227-N
UMC Haralson Memorial Loan Fund established, 308-N
UMC med student of the year named, 226-N
UMC now has an EMI scanner, 363-N
UMC presents M.D. degree to 101 graduates, 219-N
UMC professors of the year named, 222-N
UMC researchers study thyroid hormones, 225-N
ventilator techniques studied at UMC, 284-N

University of Miami School of Medicine
postgraduate course set for Bal Harbour, 20A-N

University of Mississippi School of Pharmacy
state pharmacists have new publication, 131-N
UM hypertension conference held, 365-N
VD awareness program held in Oxford, 163-N

University of Southern Mississippi
psychiatric grants go to schools, 22-N

Urology
carcinoma of the penis [Elliott et al] *321
genitourinary radiology course set, 151-N
hypospadias: a general review [Keeton and Fenter] *340
spontaneous closure of a renal arteriovenous fistula [Trapp et al] *91-RS

Utilization Review
new UR regulations are postponed, 160-N

V

Venereal Disease
gonorrhea [Henderson] *38
VD awareness program held in Oxford, 163-N

W

West Mississippi Medical Society
Dr. J. T. Davis is guest of, 26-N

Woman's Auxiliary
Dr. Davis speaks to, 88-N
Mrs. Opal Dees is SMA auxiliary president-elect, 87-N
supports UMC children's hospital, 388-N
WA/MSMA page, 362
WA/MSMA—52nd annual session program, 105

X

X-Ray See **Radiology** and **Radiologic Seminars.**

Z

Zollinger, Robert M.
headlines UMC surgical forum, 22-N

AUTHOR INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "MLB," Medico-Legal Briefs; "BR," Book Review; "CPC," Clinicopathological Conference; "AP,' Auxiliary Page. The asterisk (*) indicates an original article in the Journal.

A

Atkinson, Jack A., 182-PP, 216-PP, 276-PP, 294-PP, 328-PP, 350-PP, 378-PP

B

Bennett, Kenneth R., *172
Blakey, Durward L., 14-E, 46-L, 115-E, 153-E, 281-L, 332-L, 384-L
Bland, James R., 280-L
Blount, Richard L., 47-BR
Bower, John D., *1, *367
Blumenthal, Bernard, *209-RS
Boronow, Richard C., *61
Brent, Alvin E., *1
Brooks, T. J., Jr., *67, 121-BR, 183-E

C

Caccamise, Charles, 116-L
Carter, Kenneth G., *178-RS, 381-BR
Champion, James T., 121-BR

D

Dabney, W. Moncure, 13-E, 115-E, 277-E, 379-E
Daniel, C. Ralph, Jr., *367
Daniel, C. Ralph, III, *367
Davis, J. T., 12-PP, 44-PP, 78-PP, 114-PP, 152-PP, *211
Dear, H. Davis, *205
Derian, Paul S., 187-BR
Dryja, Robert A., *142

E

Edwards, C. Mims, 280-L
Elliott, John P., Jr., *91-RS, *321
Evans, John, *91-RS, *321

F

Fenter, Thomas C., *340
Flowers, W. M., Jr., *9-RS
Frazier, Claude A., 156-L, 356-L

G

Galyean, James R., III, *167
Gibson, John Y., *74-RS, 79-E, *291-RS, *373-RS
Gibson, Nola, 154-E
Godfrey, William E., II, 85-BR
Gordon, James, *91-RS, *321

H

Harris, Elmer J., *149-RS
Henderson, Ralph H., *38
Henderson, Robert P., *42-RS
Hester, Clifton L., Jr., *323-RS
Hilbun, Benton M., 279-BR
Holman, Melvin R., 333-BR

J

Jacobs, Keith W., *35

K

Kees, C. Jay, *31
Keeton, James E., *340
Kilgore, Thomas L., *201, *205, *285, *288

L

Lampton, T. D., *142
Langford, Herbert G., 333-BR
Laughlin, Victor C., 81-L
Layton, Richard G., 306-L
Leist, Steve C., 381-BR
Lockey, Myron W., 351-E
Long, Bill W., *31, *137, *337

M

Martin, George H., 45-E, 153-E, 295-E
Mathews, Charles L., 13-E, 217-E, 329-E
McMullan, Martin H., *201, *205, *285, *288
Miller, Richard C., *326, *343
Morrison, Francis S., *337

N

Norman, Joe R., 355-BR

O

Odom, C. Douglas, *61

P

Platt, Lucas O., *91-RS, *321
Price, Beulah M., *7, *376
Puckett, Thomas F., 21-BR

R

Reid, Lee R., *315
Renick, Oren, *326, *343
Roberts, William F., 277-MLB
Rogers, Joseph B., 85-BR
Russell, John F., 356-BR

S

Sams, James H., 299-BR
Sanders, Jane A., *9-RS
Sauls, Jeffrey L., *346-RS
Sisson, Charles A., Jr., 279-BR
Smith, McKamy, *205
Smith, Trent W., 357-L

T

Thigpen, J. Tate, *337
Todd, Malcolm C., 81-L
Trapp, James, *91-RS

W

Warren, Richard B., Jr., *137
Wiener, William B., *371

TABLE OF PAGES

January	1	to	30	July	201	to	230
February	31	to	60	August	231	to	284
March	61	to	90	September	285	to	314
April	91	to	136	October	315	to	336
May	137	to	166	November	337	to	366
June	167	to	200	December	367	to	400

Transactions of the House of Delegates . . . . . 231 to 267

By-Laws of the Association . . . . . 268 to 275

10 7358

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